An 18-year-old man is brought to the clinic by his mother due to increasingly bizarre behavior over the past 2 months. The patient is in his first semester at an out-of-state college and has had difficulty adjusting to being away from home. For the past few weeks, he has not been attending classes, and he no longer socializes with friends. The patient spends most of his time alone in his dorm room and eats very little because he believes the cafeteria food is poisoned. He has no significant medical or psychiatric history and does not use alcohol or illicit drugs. Physical examination is unremarkable. On mental status examination, he appears disheveled with unwashed hair, makes poor eye contact, and shouts "leave me alone" in response to unseen people. Which of the following is the most likely diagnosis in this patient?

- A. Adjustment disorder
- B. Brief psychotic disorder
- C. Delusional disorder
- D. Major depressive disorder with psychotic features
- E. Schizophrenia
- F. Schizophreniform disorder

Submit

An 18-year-old man is brought to the clinic by his mother due to increasingly bizarre behavior over the past 2 months. The patient is in his first semester at an out-of-state college and has had difficulty adjusting to being away from home. For the past few weeks, he has not been attending classes, and he no longer socializes with friends. The patient spends most of his time alone in his dorm room and eats very little because he believes the cafeteria food is poisoned. He has no significant medical or psychiatric history and does not use alcohol or illicit drugs. Physical examination is unremarkable. On mental status examination, he appears disheveled with unwashed hair, makes poor eye contact, and shouts "leave me alone" in response to unseen people. Which of the following is the most likely diagnosis in this patient?

- A. Adjustment disorder (8%)
- B. Brief psychotic disorder (6%)
- C. Delusional disorder (3%)
- D. Major depressive disorder with psychotic features (7%)
- E. Schizophrenia (9%)
- ✓ F. Schizophreniform disorder (65%)

Omitted
Correct answer
F

65%
Answered correctly

03 secs
Time Spent

02/08/2020
Last Updated

Explanation

Differential diagnosis of DSM-5 psychotic disorders	
Brief psychotic	

Differential diagnosis of DSM-5 psychotic disorders	
Brief psychotic disorder	**≥1 days & <1 month**, sudden onset, full return to function
Schizophreniform disorder	**≥1 months & <6 months**, same symptoms as schizophrenia, functional decline not required
Schizophrenia	**≥6 months** (includes ≥1 months of active symptoms, can include prodromal & residual periods), requires functional decline
Schizoaffective disorder	Mood episode with concurrent active-phase symptoms of schizophrenia + ≥2 weeks of delusions or hallucinations in the absence of prominent mood symptoms
Delusional disorder	**≥1 delusions & ≥1 months**, **no other psychotic symptoms**, normal functioning apart from direct impact of delusions

This patient's 2-month history of progressive social withdrawal, paranoid ideation, and auditory hallucinations suggests **schizophreniform disorder**. These patients exhibit the **same symptoms as** individuals with **schizophrenia** (delusions, hallucinations, disorganized speech and behavior, negative symptoms) but for a **shorter duration** (≥1 month and <6 months). Functional decline, although often present, is not required for diagnosis.

As with all psychotic disorders, diagnosis requires ruling out medical and substance-induced etiologies. Schizophreniform disorder is often a provisional diagnosis that requires longitudinal monitoring, as approximately two-thirds of patients with this disorder are eventually diagnosed with schizophrenia or schizoaffective disorder.

(Choice A) Adjustment disorder is characterized by increased anxiety, depressive symptoms, and/or disruptive behavior (eg, agitation, property destruction) that develops within 3 months of an identifiable stressor and lasts no more than 6 months after the stressor ends. Symptoms of acute psychosis are not present in patients with adjustment disorder.

(Choices B and E) This patient's symptom duration of 2 months rules out these disorders. In brief psychotic disorder, psychotic symptoms last at

behavior, negative symptoms) but for a **shorter duration** (≥1 month and <6 months). Functional decline, although often present, is not required for diagnosis.

As with all psychotic disorders, diagnosis requires ruling out medical and substance-induced etiologies. Schizophreniform disorder is often a provisional diagnosis that requires longitudinal monitoring, as approximately two-thirds of patients with this disorder are eventually diagnosed with schizophrenia or schizoaffective disorder.

(Choice A) Adjustment disorder is characterized by increased anxiety, depressive symptoms, and/or disruptive behavior (eg, agitation, property destruction) that develops within 3 months of an identifiable stressor and lasts no more than 6 months after the stressor ends. Symptoms of acute psychosis are not present in patients with adjustment disorder.

(Choices B and E) This patient's symptom duration of 2 months rules out these disorders. In brief psychotic disorder, psychotic symptoms last at least 1 day but <1 month, with full return to premorbid functioning. A diagnosis of schizophrenia requires symptom duration of ≥6 months.

(Choice C) In delusional disorder, other psychotic symptoms (eg, hallucinations, disorganized speech and behavior) are not present, behavior is not obviously bizarre, and functioning is not markedly impaired apart from the impact of the delusion.

(Choice D) There are insufficient symptoms to diagnose a major depressive episode. This patient's social withdrawal is a negative symptom characteristic of psychosis, and his appetite disturbance is due to the paranoid delusions about food being poisoned.

Educational objective:
Schizophreniform disorder is characterized by psychotic symptoms (delusions, hallucinations, disorganized speech and behavior, negative symptoms) lasting ≥1 month and <6 months.

References

- Schizophrenia and other psychotic disorders in DSM-5.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Psychosis
Subject	System	Topic

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A 34-year-old man comes to the office with a 5-day history of nasal congestion and cough. He says that he occasionally coughs up thick, yellow sputum and is worried about the lack of improvement. The patient mentions that he has received antibiotics for similar symptoms in the past and says, "Antibiotics always seem to help me feel better fast." Temperature is 37.2 C (99 F), blood pressure is 120/70 mm Hg, pulse is 76/min, and respirations are 18/min. Physical examination shows pharyngeal erythema; the remainder of the examination, including cardiopulmonary evaluation, is normal. Which of the following responses by the physician is most appropriate?

A. "Although you've experienced improvement with antibiotics in the past, your symptoms will likely improve with over-the-counter treatment."

B. "Antibiotics can be helpful for certain infections, but I'm concerned you may have been prescribed antibiotics inappropriately in the past."

C. "Feeling sick is unpleasant; let's talk about why antibiotics are not recommended and what treatments can help you feel better."

D. "I understand why you want me to prescribe antibiotics, but this would only lead to antibiotic resistance."

E. "Many patients think antibiotics can help treat colds; unfortunately, there are no quick fixes for viral infections."

Submit

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A. "Although you've experienced improvement with antibiotics in the past, your symptoms will likely improve with over-the-counter treatment." (5%)

B. "Antibiotics can be helpful for certain infections, but I'm concerned you may have been prescribed antibiotics inappropriately in the past." (2%)

✓ C. "Feeling sick is unpleasant; let's talk about why antibiotics are not recommended and what treatments can help you feel better." (88%)

D. "I understand why you want me to prescribe antibiotics, but this would only lead to antibiotic resistance." (2%)

E. "Many patients think antibiotics can help treat colds; unfortunately, there are no quick fixes for viral infections." (1%)

Omitted
Correct answer
C

88%
Answered correctly

01 sec
Time Spent

06/24/2020
Last Updated

Explanation

This afebrile patient with a normal lung examination most likely has a **viral upper respiratory infection**. The physician is faced with the common clinical issue of responding to a **request for an unnecessary antibiotic** prescription. Although many patients receive antibiotics for upper respiratory infections, antibiotic use in uncomplicated upper respiratory infections is associated with increased **risk of adverse effects**, no

Explanation

This afebrile patient with a normal lung examination most likely has a **viral upper respiratory infection**. The physician is faced with the common clinical issue of responding to a **request for an unnecessary antibiotic** prescription. Although many patients receive antibiotics for upper respiratory infections, antibiotic use in uncomplicated upper respiratory infections is associated with increased **risk of adverse effects**, no improvement compared to placebo, and a rise in **antibiotic resistance**.

The most appropriate response is a **patient-centered approach** that **validates** the patient's concerns, **educates** the patient about the adverse effects of antibiotics and their lack of efficacy in treating viral infections, and **provides options** to treat the patient symptomatically. This must be done in an empathic and nonjudgmental fashion that helps build, not undermine, the physician-patient relationship. The physician should refrain from prescribing antibiotics and advise the patient to return if symptoms persist or worsen.

(Choice A) This statement does not explain why antibiotics are not an appropriate treatment at this time and may be interpreted as dismissive given the patient's specific request.

(Choice B) Although this may be true, it is not constructive to criticize previous treatment providers.

(Choice D) Although it is appropriate to explain that unnecessary antibiotic use can contribute to general antibiotic resistance, this response is not patient centered because it dismisses the patient's concerns and does not explain why antibiotics are inappropriate for his specific symptoms.

(Choice E) This statement fails to explain why antibiotics are inappropriate and does not offer any treatment options. It may be perceived as invalidating or judgmental and have a detrimental effect on the physician-patient relationship.

Educational objective:
Empiric antibiotic therapy for patients with uncomplicated upper respiratory infections is contraindicated. Responding to requests for inappropriate antibiotics involves a patient-centered approach that validates the patient's concerns, educates the patient about the adverse effects of antibiotics and their lack of efficacy in treating viral infections, and provides options to treat the patient symptomatically.

References

- Patient-centered communication: basic skills.

A 32-year-old man comes to the office due to disabling anxiety. The patient was recently promoted to his company's headquarters, requiring him to work on the 48th floor of the building. As soon as he steps on the elevator, he feels panicky and faint, sweats profusely, and has heart palpitations. The patient is worried that he might have to resign if he is unable to control his anxiety. His fear of elevators dates back to childhood. He drinks 1 or 2 beers on weekends but does not use tobacco or illicit drugs. Which of the following is the most effective long-term treatment for this patient's condition?

A. Alprazolam
B. Cognitive-behavioral therapy
C. Escitalopram
D. Propranolol
E. Psychodynamic psychotherapy
F. Supportive psychotherapy
G. Venlafaxine

Submit

A 32-year-old man comes to the office due to disabling anxiety. The patient was recently promoted to his company's headquarters, requiring him to work on the 48th floor of the building. As soon as he steps on the elevator, he feels panicky and faint, sweats profusely, and has heart palpitations. The patient is worried that he might have to resign if he is unable to control his anxiety. His fear of elevators dates back to childhood. He drinks 1 or 2 beers on weekends but does not use tobacco or illicit drugs. Which of the following is the most effective long-term treatment for this patient's condition?

- A. Alprazolam (1%)
- ✓ B. Cognitive-behavioral therapy (72%)
- C. Escitalopram (6%)
- D. Propranolol (2%)
- E. Psychodynamic psychotherapy (8%)
- F. Supportive psychotherapy (3%)
- G. Venlafaxine (4%)

Omitted
Correct answer
B

72%
Answered correctly

02 secs
Time Spent

02/03/2020
Last Updated

Explanation

Specific phobia	

Specific phobia	
History & clinical features	• Marked anxiety about a **specific** object or situation (the phobic stimulus) for >6 months • Common types: fear of flying, heights, animals, injections, blood • Avoidance behavior (eg, avoiding bridges & elevators, refusing work requiring travel) • Common (10% of population) • Usually develops in childhood, often after traumatic event
Treatment	• Cognitive-behavioral therapy with exposure (first-line) • Short-acting benzodiazepines (limited role, may help acutely if therapist unavailable or insufficient time)

This patient's marked and immediate fear in a **specific situation** (ie, elevator as phobic stimulus) is consistent with a **specific phobia**. Although he feels panicky when confronted with the phobic stimulus, he does not have unexpected panic attacks as in panic disorder.

Cognitive-behavioral therapy, involving systematic, **repeated exposure** to the phobic stimulus, is the treatment of choice for specific phobia. Exposure is typically performed in a gradual, **step-wise manner**, resulting in decreased anxiety over time as habituation and extinction occur. Confrontation with the phobic stimulus in a safe and controlled manner can be accomplished through in vivo (most effective), imaginal, and virtual reality exposure techniques.

(Choice A) Benzodiazepines (eg, alprazolam) can be used in the acute treatment of specific phobia when there is lack of time, no available therapist, or infrequent encounters. It could be considered in the short-term treatment of this patient's anxiety while cognitive-behavioral therapy takes effect. Benzodiazepines, however, carry the risks of dependence, rebound anxiety, and cognitive impairment and would not be the appropriate long-term choice for this patient who must encounter the phobic stimulus at work on a daily basis.

(Choices C and G) Escitalopram (a selective serotonin reuptake inhibitor), and venlafaxine (a serotonin-norepinephrine reuptake inhibitor) are used to treat depression in addition to panic disorder, generalized anxiety disorder, and social anxiety disorder. They are not first-line treatments for specific phobia.

(Choice D) The beta blocker propranolol has been used to treat performance anxiety (a subtype of social anxiety disorder) but is not useful for specific phobia.

reality exposure techniques.

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(Choice D) The beta blocker propranolol has been used to treat performance anxiety (a subtype of social anxiety disorder) but is not useful for specific phobia.

(Choices E and F) These forms of psychotherapy would not address this patient's specific phobia directly. Psychodynamic psychotherapy focuses on developing insight into unresolved conflicts and the influence of past relationships on current life situations. Supportive psychotherapy is aimed at bolstering adaptive psychological defenses to help individuals cope with acute crises or chronic psychiatric illness.

Educational objective:
Exposure-based cognitive-behavioral therapy, in which patients are systematically confronted with their feared objects or situations, is the most effective long-term treatment for specific phobia.

References

- Specific phobias.
- Specific phobia.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Specific phobia
Subject	System	Topic

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An 18-year-old boy is brought to the emergency department by his mother due to his strange behavior. The mother says that he laughs inappropriately and seems sluggish. The boy has recently been hanging out with a new group of friends that he describes as "really cool." He has also stopped attending family events and appears apathetic about his schoolwork. When asked in private, the boy admits smoking marijuana. Which of the following physiologic effects is most likely to be observed in this patient?

- A. Bradycardia
- B. Conjunctival injection
- C. Miosis
- D. Mydriasis
- E. Nystagmus
- F. Respiratory depression

Submit

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- A. Bradycardia (4%)
- ✓ B. Conjunctival injection (80%)
- C. Miosis (4%)
- D. Mydriasis (7%)
- E. Nystagmus (1%)
- F. Respiratory depression (1%)

Omitted
Correct answer
B

80%
Answered correctly

01 sec
Time Spent

02/01/2020
Last Updated

Explanation

Marijuana (cannabis) is one of the most commonly used drugs in the United States. It is a cannabinoid that contains the active ingredient tetrahydrocannabinol (THC). Smoking is the preferred route of delivery, and once inhaled, marijuana produces effects that last from 1-4 hours. THC stimulates cannabinoid receptors (CB1 and CB2 receptors) to produce effects on mood, perception, and cognition.

Marijuana produces a mild euphoria with inappropriate laughter, sedation, slowed reflexes, impaired motor coordination, distorted sensory perceptions, and cognitive impairment (decreased attention, concentration, short-term memory, and judgment). The most characteristic

Explanation

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Marijuana produces a mild euphoria with inappropriate laughter, sedation, slowed reflexes, impaired motor coordination, distorted sensory perceptions, and cognitive impairment (decreased attention, concentration, short-term memory, and judgment). The most characteristic physiological signs of marijuana intoxication are **conjunctival injection (red eyes), tachycardia, increased appetite, and dry mouth.**

Marijuana is metabolized in the liver, distributed and stored in lipophilic tissues, and slowly released. It remains in the body for a long time; depending on the amount and frequency of use, it can be detected in the urine up to 30 days after daily use has ceased.

(Choices A and F) Cannabis intoxication results in tachycardia and does not cause respiratory depression. Bradycardia can occur with GHB (gamma hydroxybutyric acid), opiate, or benzodiazepine intoxication. In toxic doses, all three central nervous system depressants can cause respiratory depression.

(Choice C) Miosis (constricted, pinpoint pupils) is commonly seen in opiate intoxication.

(Choice D) Mydriasis (dilated pupils) occurs in cocaine intoxication and opiate withdrawal.

(Choice E) Nystagmus is a rhythmic, regular oscillation of the eyes and is commonly seen with phencyclidine (PCP) intoxication.

Educational objective:
Marijuana contains tetrahydrocannabinol, which stimulates cannabinoid receptors to produce a mild euphoria with inappropriate laughter, increased appetite, slowed reaction time/motor speed, and cognitive impairment. Tachycardia and conjunctival injection are the 2 most immediate physical symptoms of marijuana use.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Cannabis
Subject	System	Topic

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A 5-year-old boy is brought to the office by his mother for a checkup. He is healthy and about to start kindergarten. His mother is concerned about his recent reaction to her brother's death. "Although I told him that Uncle John died and can't be with us anymore, he insists that he is coming for his birthday and will take him to a ballgame. He died over 3 months ago, but my son repeatedly asks me when he is coming back. When I try to explain, he starts crying that his stomach hurts." Physical examination is normal. During the examination he tells the physician, "I try to clean up my toys before bedtime so mommy won't cry." Which of the following is the most likely explanation for the patient's behavior?

A. Age-appropriate behavior
B. Complicated grief reaction
C. Developmental delay
D. Post-traumatic stress disorder
E. Regression
F. Somatic symptom disorder

Submit

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- ✓ A. Age-appropriate behavior (74%)
- B. Complicated grief reaction (17%)
- C. Developmental delay (0%)
- D. Post-traumatic stress disorder (1%)
- E. Regression (2%)
- F. Somatic symptom disorder (3%)

Omitted
Correct answer
A

74%
Answered correctly

02 secs
Time Spent

06/17/2020
Last Updated

Explanation

Bereavement reactions in children depend on the child's age. **Preschool children** (age <6) may **not understand the finality of death** and can exhibit **magical thinking** in which they fully expect that a dead person can come back to life. Younger children may also attribute events or other's reactions to something they did wrong due to an **egocentric** thought process (eg, this child believing that he causes his mother's crying). Death should be explained to them in concrete terms, and they should be reassured that other people's grief is not their fault.

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(Choice B) This child's reactions are age-appropriate. Complicated grief (also known as persistent complex bereavement disorder) is characterized by prolonged grief, excessive yearning for the deceased, and inability to move on with life.

(Choice C) This boy's behavior (not understanding death) is appropriate for a 5-year-old; in contrast, children age ≥7 are typically aware that death is final.

(Choice D) Post-traumatic stress disorder requires exposure to a life-threatening event that continues to be reexperienced in the form of flashbacks and nightmares. In preschool children this can be manifested by repetitive play about the event, frightening nightmares, and mood or behavioral changes (eg, temper tantrums, separation anxiety).

(Choice E) Regression refers to returning to a former, less developed stage of development. It is often seen in response to traumatic or anxiety-provoking situations (eg, if this child started wetting the bed following a stressful event after having achieved continence previously).

(Choice F) Children commonly develop somatic symptoms as a nonverbal expression of psychological distress. This child is not excessively focused on his stomachaches to the extent of impairment, as would be seen in somatic symptom disorder.

Educational objective:
Preschool children have not developed an understanding of the finality of death, which typically occurs around age 7. They may have magical thoughts that death is temporary or reversible and believe that other people's grief is their fault.

References

- Exploring children's understanding of death: through drawings and the Death Concept Questionnaire.
- Predictors of children's understandings of death: age, cognitive ability, death experience and maternal communicative competence.
- Sources of children's knowledge about death and dying.

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A 27-year-old man is brought to a family therapist by his wife following a violent outburst in which he nearly injured her. They were having what seemed like a minor argument over a miscommunication about her being late when he suddenly flew into a rage, started shouting, and threw several plates against the wall. His wife is now threatening to leave him because similar episodes keep happening despite his promise to control his anger. The patient is remorseful and says, "I have been getting into trouble because of my temper since high school. Once I get angry, I feel out of control and it's impossible to stop." The patient has no medical history. He drinks beer and uses cannabis to relax approximately 2-3 times a month. Which of the following is the most likely diagnosis in this patient?

A. Antisocial personality disorder
B. Bipolar disorder, manic episode
C. Borderline personality disorder
D. Conduct disorder
E. Disruptive mood dysregulation disorder
F. Intermittent explosive disorder
G. Phencyclidine intoxication

Submit

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A. Antisocial personality disorder (6%)
B. Bipolar disorder, manic episode (2%)
C. Borderline personality disorder (7%)
D. Conduct disorder (5%)
E. Disruptive mood dysregulation disorder (24%)
✓ F. Intermittent explosive disorder (52%)
G. Phencyclidine intoxication (1%)

Omitted
Correct answer
F

52%
Answered correctly

01 sec
Time Spent

05/23/2020
Last Updated

Explanation

This patient's repetitive outbursts of impulsive aggression that are grossly disproportionate to the situation is suggestive of **intermittent explosive**

This patient's repetitive outbursts of impulsive aggression that are grossly disproportionate to the situation is suggestive of **intermittent explosive disorder** (IED), an impulse control disorder. Patients with IED often feel a sense of heighted arousal or tension that quickly escalates to rage and **uncontrollable impulses** to be **verbally** or **physically aggressive**. Outbursts may provide an immediate sense of relief that is usually followed by remorse. Patients can be assaultive and destroy property, resulting in significant functional impairment due to interpersonal difficulties, school suspension, job loss, and legal problems.

IED is not diagnosed if the violent behavior is premeditated or better explained as a manifestation of another disorder, such as a manic episode of bipolar disorder or substance intoxication. Treatment consists of cognitive-behavioral therapy and pharmacotherapy with selective serotonin reuptake inhibitors.

(Choices A and D) Aggressive behavior is common in antisocial personality disorder and conduct disorder, but it is often premeditated with the goal of intimidating others. This patient's behavior is not premeditated, and he does not show other antisocial features such as lawbreaking, lying, chronic irresponsibility, and lack of remorse. Conduct disorder is diagnosed in children, whereas antisocial personality disorder is diagnosed in patients age ≥18.

(Choice B) Patients with acute mania can be verbally or physically aggressive. However, this patient does not show other features of mania necessary for this diagnosis (ie, euphoric mood, increased energy and goal-directed activity, decreased need for sleep, pressured speech, grandiosity).

(Choice C) Patients with borderline personality disorder may become enraged in response to interpersonal conflicts but are not typically aggressive physically. This patient lacks other characteristic borderline features (eg, suicidal behavior, feelings of emptiness, fears of abandonment).

(Choice E) Patients with disruptive mood dysregulation disorder may also present with frequent verbal or physical outbursts. However, this is a childhood diagnosis that requires an onset age <10 and persistent irritability or anger between episodes.

(Choice G) Phencyclidine intoxication can present with violent behavior and is typically associated with nystagmus. It is unlikely to explain his pattern of impulsive, angry outbursts since high school.

Educational objective:
Intermittent explosive disorder is characterized by recurrent episodes of explosive verbal or physical aggression. The aggressive behaviors are impulsive and grossly out of proportion to the provocation.

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References

- Intermittent explosive disorder as a disorder of impulsive aggression for DSM-5.
- Verbal versus physical aggression in intermittent explosive disorder.
- Psychosocial impairment in DSM-5 intermittent explosive disorder.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Impulse control disorders
Subject	System	Topic

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A 46-year-old man is admitted to the hospital for atypical chest pain. His medical history is significant for hypertension controlled with amlodipine and hypercholesterolemia treated with atorvastatin; he has a family history of depression and heart disease. During review of his substance use history, the patient says that he has been a "regular drinker" for the last 5 years. He drinks a 6-pack of beer every night and has 2 more beers in the morning to help him "get through the day." He also admits to smoking marijuana occasionally but does not use tobacco or other illicit drugs. Which of the following symptoms or signs is most likely to appear earliest during this patient's hospitalization?

A. Fluctuating arousal level
B. Hypersomnolence
C. Nystagmus
D. Tonic-clonic seizures
E. Tremulousness
F. Visual hallucinations

Submit

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- A. Fluctuating arousal level (6%)
- B. Hypersomnolence (4%)
- C. Nystagmus (2%)
- D. Tonic-clonic seizures (4%)
- ✓ E. Tremulousness (75%)
- F. Visual hallucinations (6%)

Omitted
Correct answer
E

75%
Answered correctly

01 sec
Time Spent

03/09/2020
Last Updated

Explanation

Alcohol withdrawal syndrome		
Manifestations	Symptoms/signs	Onset since last drink (hr)

Alcohol withdrawal syndrome		
Manifestations	**Symptoms/signs**	**Onset since last drink (hr)**
Mild withdrawal	Anxiety, insomnia, tremors, diaphoresis, palpitations, gastrointestinal upset, intact orientation	6-24
Seizures	Single or multiple generalized tonic-clonic	12-48
Alcoholic hallucinosis	Visual, auditory, or tactile; intact orientation; stable vital signs	12-48
Delirium tremens	Confusion, agitation, fever, tachycardia, hypertension, diaphoresis, hallucinations	48-96

Ethanol use leads to a number of biochemical changes in the CNS. It acutely potentiates the effects of GABA (the primary inhibitory neurotransmitter in the CNS) at GABA-A receptors, leading to sedation. **Chronic ethanol use** causes downregulation of **GABA receptors**. Alcohol also weakly inhibits excitatory NMDA receptors in the brain, and chronic exposure leads to upregulation of these receptors. These adaptive changes result in tolerance (ie, the need to increase the dose to achieve the desirable effect) and symptoms of withdrawal on abrupt alcohol cessation, a common occurrence during hospital admission. Both tolerance and withdrawal are signs of substance dependence.

Withdrawal symptoms can begin as early as **6 hours** after the patient's last drink, typically reach maximal intensity in 2-3 days, and subside in 4-5 days if the withdrawal is not severe. **Tremor**, or "the shakes," is the most common **initial finding**. Patients also typically have signs of mild autonomic dysfunction (eg, increased heart rate and respirations), gastrointestinal distress (eg, nausea, vomiting), and anxiety.

(Choice A) Fluctuating arousal levels are characteristic of delirium tremens, a potentially fatal manifestation of alcohol withdrawal that typically begins 48-96 hours after the last drink. Other findings include sympathetic hyperactivity (eg, hyperthermia, hypertension), hallucinations (eg, visual, auditory, and/or tactile), and confusion.

Delirium tremens	Confusion, agitation, fever, tachycardia, hypertension, diaphoresis, hallucinations	48-96

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(Choices B and C) Hypersomnolence and nystagmus can occur in acute ethanol intoxication but are not common during alcohol withdrawal. Most patients have insomnia attributable to increased CNS excitability during the withdrawal period.

(Choice D) Tonic-clonic seizures can occur 12-48 hours after the last drink and affect <5% of patients undergoing alcohol withdrawal.

(Choice F) Alcoholic hallucinosis (ie, visual hallucinations) can develop within 12-48 hours after the last drink. These early hallucinations are distinct from delirium tremens.

Educational objective:
Tremulousness is typically one of the earliest symptoms of alcohol withdrawal. Other common symptoms include gastrointestinal distress, agitation, anxiety, and autonomic disturbance. Delirium tremens is the most severe manifestation of alcohol withdrawal and typically begins 48-96 hours after the last drink.

References

- The emergency medicine management of severe alcohol withdrawal.

alcohol cessation, a common occurrence during hospital admission. Both tolerance and withdrawal are signs of substance dependence.

Withdrawal symptoms can begin as early as **6 hours** after the patient's last drink, typically reach maximal intensity in 2-3 days, and subside in 4-5 days if the withdrawal is not severe. **Tremor**, or "the shakes," is the most common **initial finding**. Patients also typically have signs of mild autonomic dysfunction (eg, increased heart rate and respirations), gastrointestinal distress (eg, nausea, vomiting), and anxiety.

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(Choice F) Alcoholic hallucinosis (ie, visual hallucinations) can develop within 12-48 hours after the last drink. These early hallucinations are distinct from delirium tremens.

Educational objective:
Tremulousness is typically one of the earliest symptoms of alcohol withdrawal. Other common symptoms include gastrointestinal distress, agitation, anxiety, and autonomic disturbance. Delirium tremens is the most severe manifestation of alcohol withdrawal and typically begins 48-96 hours after the last drink.

References

- The emergency medicine management of severe alcohol withdrawal.
- Identification and management of alcohol withdrawal syndrome.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Alcohol withdrawal
Subject	System	Topic

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A 25-year-old man is brought to the emergency department by ambulance after being found sitting in the street drinking his own urine. The patient's mother says that a year ago he expressed the belief that he was being watched by an unidentified government agency and subsequently broke up with his girlfriend, quit his job, and disconnected his phone. The patient's mother has noticed that he no longer seems to care about activities that used to interest him, and last month she found out that he had moved into the family garden shed with his dog. On examination, the patient is malodorous, disheveled, and laughs for no apparent reason. He later becomes angry and refuses to sit in a chair for the interview. The patient switches among unrelated topics and when asked where he lives says, "in the holy buffet of diplomacy." Temperature is 36.7 C (98 F), blood pressure is 122/79 mm Hg, and pulse is 80/min. Physical examination and laboratory evaluation, including urine toxicology, are unremarkable. Which of the following is the most likely diagnosis in this patient?

A. Bipolar I disorder
B. Brief psychotic disorder
C. Major depression with psychotic features
D. Psychotic disorder due to a general medical condition
E. Schizoaffective disorder
F. Schizophrenia
G. Schizophreniform disorder

Submit

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- A. Bipolar I disorder (3%)
- B. Brief psychotic disorder (0%)
- C. Major depression with psychotic features (3%)
- D. Psychotic disorder due to a general medical condition (0%)
- E. Schizoaffective disorder (7%)
- ✓ F. Schizophrenia (81%)
- G. Schizophreniform disorder (2%)

Omitted
Correct answer
F

81%
Answered correctly

01 sec
Time Spent

02/24/2020
Last Updated

Explanation

Schizophrenia	
Diagnosis	• ≥2 of the following (at least 1 symptom from 1-3) 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Disorganized or catatonic behavior 5. Negative symptoms (eg, apathy, flat affect) • Continuous impairment ≥6 months • Significant functional decline
Treatment	• Antipsychotic medication • Adjunctive psychosocial interventions (eg, social skills training, cognitive-behavioral therapy, family intervention)

This patient's **delusions**, **disorganized speech** (eg, loosening of associations, nonsensical words), **grossly disorganized behavior** (eg, unpredictable agitation, bizarre behaviors, inappropriate affect), and functional decline lasting ≥6 months are consistent with **schizophrenia**. Other symptoms include **hallucinations** and **negative symptoms** (eg, affective flattening, apathy, alogia [poverty of speech], anhedonia, asociality).

Schizophrenia has an overall international prevalence of almost 1% and is slightly more prevalent among men. Schizophrenia typically presents in the early 20s in men and the late 20s in women. The majority of patients with schizophrenia follow a fluctuating course in which symptoms peak (as seen in this patient) and then diminish, with less severe residual symptoms (eg, disorganization, mild negative symptoms, mild hallucinations) at baseline. The treatment of choice for schizophrenia is antipsychotic medication.

(Choices A and C) In bipolar disorder or major depressive disorder (MDD) with psychotic features, psychotic symptoms occur exclusively during a major depressive or manic episode. This patient's apathy and anhedonia are negative symptoms of schizophrenia. Although anhedonia is also seen in MDD, this patient does not have other depressive symptoms required to diagnose MDD.

(Choices B and G) Brief psychotic disorder is characterized by acute onset of psychotic symptoms lasting ≥1 day but <1 month, with full return to

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(Choices B and G) Brief psychotic disorder is characterized by acute onset of psychotic symptoms lasting ≥1 day but <1 month, with full return to premorbid level of functioning. Schizophreniform disorder is distinguished from schizophrenia by a symptom duration of >1 month and <6 months. Because this patient's symptoms have lasted ≥6 months, he meets the criteria for schizophrenia.

(Choice D) Although it is important to definitively rule out medical causes of psychosis, this patient's normal vital signs and unremarkable physical examination and laboratory evaluation make a primary psychiatric disorder more likely.

(Choice E) Schizoaffective disorder requires that the patient meet the criteria for a major depressive or manic episode concurrent with active-phase symptoms of schizophrenia. The diagnosis also requires that delusions or hallucinations occur in the absence of mood symptoms for ≥2 weeks at some point during the illness.

Educational objective:
The diagnosis of schizophrenia requires ≥2 of the following 5 symptoms: delusions, hallucinations, disorganized speech, grossly disorganized behavior, and negative symptoms. The total impairment duration must be ≥6 months.

References

- Definition and description of schizophrenia in the DSM-5.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Schizophrenia
Subject	System	Topic

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Schizophrenia has an overall international prevalence of almost 1% and is slightly more prevalent among men. Schizophrenia typically presents in the early 20s in men and the late 20s in women. The majority of patients with schizophrenia follow a fluctuating course in which symptoms peak (as seen in this patient) ar ns) at baseline. The treatmen

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Educational objective:
The diagnosis of schizoph behavior, and negative sy

References

- Definition and descrip

Behavioral science
Subject

Exhibit Display

Major depressive disorder	
Diagnosis	• ≥5 of the following symptoms lasting ≥2 weeks (at least 1 symptom must be either depressed mood or loss of interest/pleasure): ◦ Depressed mood ◦ Loss of interest or pleasure ◦ Change in appetite or weight ◦ Insomnia or hypersomnia ◦ Psychomotor retardation or agitation ◦ Low energy ◦ Poor concentration or indecisiveness ◦ Thoughts of worthlessness or inappropriate guilt ◦ Recurrent thoughts of death or suicide • No history of mania or hypomania • Not due to substances or another medical condition
Treatment	• Psychotherapy • Antidepressant medication

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A 45-year-old woman comes to the office with multiple scratches, small sores, and abscesses on her left arm. She is worried because the sores have been present for the past month and have not healed. The patient has no idea how the sores developed and is concerned that they will spread. She is a nurse who is well known to the staff from a similar presentation 2 years ago. At that time, she had similar skin lesions, many of which were severely infected and did not respond to usual treatment. Fecal bacteria were found in one of the sores. On another occasion, the patient had a spreading infection and cellulitis that required a prolonged hospitalization and intravenous antibiotics. She has no other medical problems. Which of the following is the most likely cause of this patient's condition?

A. Borderline personality disorder
B. Conversion disorder
C. Factitious disorder
D. Illness anxiety disorder
E. Malingering
F. Somatic symptom disorder

Submit

A 45-year-old woman comes to the office with multiple scratches, small sores, and abscesses on her left arm. She is worried because the sores have been present for the past month and have not healed. The patient has no idea how the sores developed and is concerned that they will spread. She is a nurse who is well known to the staff from a similar presentation 2 years ago. At that time, she had similar skin lesions, many of which were severely infected and did not respond to usual treatment. Fecal bacteria were found in one of the sores. On another occasion, the patient had a spreading infection and cellulitis that required a prolonged hospitalization and intravenous antibiotics. She has no other medical problems. Which of the following is the most likely cause of this patient's condition?

- A. Borderline personality disorder (3%)
- B. Conversion disorder (3%)
- ✓ C. Factitious disorder (63%)
- D. Illness anxiety disorder (4%)
- E. Malingering (17%)
- F. Somatic symptom disorder (7%)

Omitted
Correct answer
C

63%
Answered correctly

02 secs
Time Spent

05/24/2020
Last Updated

Explanation

Key features of somatic symptom & related disorders	
Somatic symptom disorder	Excessive anxiety & preoccupation with ≥1 unexplained symptoms

Key features of somatic symptom & related disorders	
Somatic symptom disorder	Excessive anxiety & preoccupation with ≥1 unexplained symptoms
Illness anxiety disorder	Fear of having a serious illness despite few or no symptoms & consistently negative evaluations
Conversion disorder (functional neurologic symptom disorder)	Neurologic symptom incompatible with known disease
Factitious disorder	Intentional falsification of illness in the absence of obvious external rewards
Malingering	Falsification or exaggeration of symptoms to obtain external rewards

This patient's likely deliberate induction of infection in the **absence** of obvious **external rewards** is consistent with factitious disorder. In **factitious disorder**, patients **deceptively produce signs and symptoms** of a medical or psychiatric illness or induce injury to obtain attention and receive protracted care (ie, to assume the "**sick role**"). Behaviors may include deceptive reporting of symptoms, manipulating laboratory samples, ingesting a substance (eg, insulin), altering medical records, or inducing illness (eg, injecting fecal matter to produce an abscess).

These patients are aware of their symptoms and conceal their attempts to simulate or cause them, but they lack conscious awareness of why they do it. When confronted with the possibility of feigning or producing symptoms, they typically respond with denial and may reject medical and psychiatric care (eg, sign out against medical advice). The presentation is often episodic and more likely to occur in women and health care workers. When an individual falsifies illness in someone else (eg, child), the diagnosis is factitious disorder imposed on another.

(Choice A) This patient has insufficient symptoms to diagnose borderline personality disorder (eg, unstable mood and relationships, impulsivity, suicidality). Patients with borderline personality disorder may engage in deliberate self-harm (eg, cutting), but it is not associated with deceiving medical caregivers.

(Choices B, D, and F) Factitious disorder can be differentiated from other somatic symptom disorders by the presence of deliberate falsification of symptoms or illness (Table). In conversion, illness anxiety, and somatic symptom disorders, patients are concerned with genuine symptoms and

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(Choices B, D, and F) Factitious disorder can be differentiated from other somatic symptom disorders by the presence of deliberate falsification of symptoms or illness (Table). In conversion, illness anxiety, and somatic symptom disorders, patients are concerned with genuine symptoms and are not attempting to deceive.

(Choice E) Malingering is differentiated from factitious disorder by the intentional falsification of symptoms for personal gain (eg, financial benefits, time off from work). In contrast, factitious disorder requires the absence of obvious rewards.

Educational objective:
Factitious disorder involves the conscious and deceptive feigning or self-production of physical or psychological symptoms to obtain attention and medical care from health care personnel.

References

- Factitious disorders and malingering: challenges for clinical assessment and management.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Factitious disorder
Subject	System	Topic

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A 26-year-old man comes to the emergency department due to chest pain, palpitations, shortness of breath, and sweating. He has been to the emergency department twice in the past month for similar symptoms. The patient has no other medical problems. He drinks 1 or 2 glasses of beer daily but does not use tobacco or illicit drugs. Family history is not significant. Blood pressure is 140/90 mm Hg, pulse is 96/min, and respirations are 20/min. ECG is normal. The patient is tremulous and says, "I feel like I'm going to die." Which of the following is the most appropriate next step in management?

A. 24-hour urine fractionated catecholamines and metanephrines

B. Benzodiazepine administration

C. Cardiac enzymes

D. Holter monitor

E. Initiation of selective serotonin reuptake inhibitor

F. Urine toxicology

Submit

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- A. 24-hour urine fractionated catecholamines and metanephrines (24%)
- ✓ B. Benzodiazepine administration (40%)
- C. Cardiac enzymes (10%)
- D. Holter monitor (3%)
- E. Initiation of selective serotonin reuptake inhibitor (7%)
- F. Urine toxicology (13%)

Omitted
Correct answer
B

40%
Answered correctly

01 sec
Time Spent

05/09/2020
Last Updated

Explanation

Panic disorder	
	• Recurrent & unexpected panic attacks with ≥4 of the following: ◦ Chest pain, palpitations, shortness of breath, choking

Panic disorder	
Clinical features	• Recurrent & unexpected panic attacks with ≥4 of the following: ◦ Chest pain, palpitations, shortness of breath, choking ◦ Trembling, sweating, nausea, chills ◦ Dizziness, paresthesias ◦ Derealization, depersonalization ◦ Fear of losing control or of dying • Worry about additional attacks, avoidance behavior
Treatment	• First-line/maintenance: SSRI/SNRI &/or cognitive-behavioral therapy • Acute distress: benzodiazepines

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

Recurrent episodes of chest pain, tachycardia, shortness of breath, sweating, and tremulousness in a young, otherwise healthy patient with a normal ECG are consistent with **panic disorder**. Classic panic attacks involve abrupt and **unexpected** onset of intense anxiety and associated symptoms that **peak within minutes**. **Somatic presentations** are **common** and include cardiac, neurologic, and gastrointestinal symptoms (Table). Fears of dying from a heart attack may prompt the patient to go to the emergency department.

Administration of a **benzodiazepine** in the emergency setting results in **rapid relief** of symptoms. Selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors are first-line pharmacologic treatments for panic disorder but would not be initiated in the emergency department as they take weeks to begin working and require ongoing monitoring **(Choice E)**.

Medical conditions that can mimic panic attacks include arrhythmias, hyperthyroidism, hyperparathyroidism, pheochromocytoma, chronic obstructive pulmonary disease, pulmonary embolus, vestibular dysfunction, and seizure disorders. Further testing should be performed when there is clinical suspicion of these disorders. Substance-induced causes of panic attacks include intoxication with central nervous system stimulants (eg, amphetamines, cocaine, caffeine) and alcohol or sedative hypnotic withdrawal.

(Choice A) Pheochromocytoma (catecholamine-secreting tumor) is a rare cause of panic symptoms and typically involves episodic headaches, sweating, tachycardia, and sustained or paroxysmal hypertension. This patient's sweating, tachycardia, and mild hypertension are more likely the

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(Choice A) Pheochromocytoma (catecholamine-secreting tumor) is a rare cause of panic symptoms and typically involves episodic headaches, sweating, tachycardia, and sustained or paroxysmal hypertension. This patient's sweating, tachycardia, and mild hypertension are more likely the result of a panic attack.

(Choices C and D) This patient's normal ECG, age, and absence of risk factors make myocardial infarction or arrhythmias unlikely.

(Choice F) There is no evidence that this patient is using substances known to cause panic symptoms.

Educational objective:
Panic disorder is characterized by recurrent, unexpected panic attacks and should be considered in young, healthy adults who come to the emergency department with unexplained chest pain.

References

- Nonfearful panic attacks in patients with noncardiac chest pain.
- Unexplained chest pain in the ED: could it be panic?

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Panic disorder
Subject	System	Topic

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A medical intern is working on the inpatient wards at a busy community hospital. During rounds, the team evaluates a new patient admitted for worsening congestive heart failure. The patient's past medical history includes atherosclerotic coronary artery disease, diabetes mellitus, and pulmonary hypertension. Current medications include metformin, aspirin, and enalapril. On previous admissions, the patient admitted to using cocaine recreationally with friends and admits to the intern that his last use was today. The attending physician asks the intern to start the patient on propranolol for his heart condition; he will be expected to continue this medication following hospital discharge. After rounds, the intern recalls that during medical school she learned that beta adrenergic antagonists can interact poorly with cocaine. Which of the following actions by the intern is most appropriate?

A. Administer the drug as the attending physician has likely considered the risks and benefits of a beta blocker in combination with cocaine

B. Discuss concerns with the nurses, ask for their input, and have them monitor the patient's vital signs when starting the medication

C. Discuss the risks and benefits of the medication with the patient and let him decide whether to take it

D. Do not order the medication as the most important principle in medicine is to "do no harm"

E. Do not order the medication until discussing concerns with the attending physician and asking how to proceed

Submit

A medical intern is working on the inpatient wards at a busy community hospital. During rounds, the team evaluates a new patient admitted for worsening congestive heart failure. The patient's past medical history includes atherosclerotic coronary artery disease, diabetes mellitus, and pulmonary hypertension. Current medications include metformin, aspirin, and enalapril. On previous admissions, the patient admitted to using cocaine recreationally with friends and admits to the intern that his last use was today. The attending physician asks the intern to start the patient on propranolol for his heart condition; he will be expected to continue this medication following hospital discharge. After rounds, the intern recalls that during medical school she learned that beta adrenergic antagonists can interact poorly with cocaine. Which of the following actions by the intern is most appropriate?

A. Administer the drug as the attending physician has likely considered the risks and benefits of a beta blocker in combination with cocaine (0%)

B. Discuss concerns with the nurses, ask for their input, and have them monitor the patient's vital signs when starting the medication (0%)

C. Discuss the risks and benefits of the medication with the patient and let him decide whether to take it (0%)

D. Do not order the medication as the most important principle in medicine is to "do no harm" (1%)

✓ E. Do not order the medication until discussing concerns with the attending physician and asking how to proceed (96%)

Omitted
Correct answer
E

96%
Answered correctly

02 secs
Time Spent

02/09/2020
Last Updated

Explanation

Interns on a medical team should not blindly follow the orders of attending physicians or physicians who have more seniority. As part of the educational process, it is essential to **understand** the **clinical reasoning** behind **team members' decisions**. It is in the best interest of both the

Explanation

Interns on a medical team should not blindly follow the orders of attending physicians or physicians who have more seniority. As part of the educational process, it is essential to **understand** the **clinical reasoning** behind **team members' decisions**. It is in the best interest of both the intern and the patient to resolve potential problems before proceeding. This concept applies to the relationship between residents and attending physicians, physicians working in parallel (eg, anesthesiologist and surgeon), and medical students and other medical staff. The best approach is to **respectfully discuss** the issue directly with the attending physician and **inquire why the decision was made**. In this case, the attending physician may feel that the cardioprotective benefit of a beta-adrenergic antagonist outweighs the potential risk of an interaction with cocaine.

(Choice A) It is unethical to blindly follow an order from an attending physician when there is concern about safety and patient care. The best course of action is to discuss the issue with the other physician and reach a consensus.

(Choice B) Although seasoned nurses will have acquired a considerable amount of medical knowledge, it is not their job to decide between the differing opinions of 2 physicians. In addition, administering a medication that could have an adverse reaction is problematic, even if vital signs are being monitored.

(Choice C) It is appropriate to explain the risks and benefits of the medication to the patient, who ultimately decides whether to take it. However, it is unprofessional to involve the patient before clarifying the rationale for the attending's recommendation.

(Choice D) It is unprofessional to refuse to follow the suggestions of an attending physician without first consulting him or her (if the attending is directly responsible for care of the patient, as in this case).

Educational objective:
Physicians are ethically obligated to question orders that raise concern about potential harm to patients. Issues should initially be discussed directly with the physician who made the order and not involve ancillary staff.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Professional conduct
Subject	System	Topic

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A 29-year-old woman comes to the office due to persistent fatigue over the last 4 years. She has also felt unhappy during this period, ever since being let go from her previous job. The patient describes her fatigue as "having little energy to do things." When asked what she enjoys, she replies that "everything in life is a chore" and that she feels hopeless that her life will improve. The patient has no suicidal thoughts, problems with concentration, or changes in appetite or sleeping patterns. She used marijuana as a teenager and drinks 1 or 2 glasses of wine on weekends. Detailed workup, including urine toxicology screen, is negative. Which of the following is the most likely diagnosis?

A. Adjustment disorder

B. Borderline personality disorder

C. Major depressive disorder

D. Persistent depressive disorder (dysthymia)

E. Substance-induced mood disorder

Submit

A 29-year-old woman comes to the office due to persistent fatigue over the last 4 years. She has also felt unhappy during this period, ever since being let go from her previous job. The patient describes her fatigue as "having little energy to do things." When asked what she enjoys, she replies that "everything in life is a chore" and that she feels hopeless that her life will improve. The patient has no suicidal thoughts, problems with concentration, or changes in appetite or sleeping patterns. She used marijuana as a teenager and drinks 1 or 2 glasses of wine on weekends. Detailed workup, including urine toxicology screen, is negative. Which of the following is the most likely diagnosis?

A. Adjustment disorder (5%)

B. Borderline personality disorder (0%)

C. Major depressive disorder (12%)

✓ D. Persistent depressive disorder (dysthymia) (80%)

E. Substance-induced mood disorder (0%)

Omitted
Correct answer
D

80%
Answered correctly

02 secs
Time Spent

05/15/2020
Last Updated

Explanation

Persistent depressive disorder (dysthymia)	
	• Chronic depressed mood ≥**2 years** (1 year in children/adolescents) • No symptom-free period for >2 months • Presence of ≥**2** of the following:

Persistent depressive disorder (dysthymia)	

Clinical features	• Chronic depressed mood ≥**2 years** (1 year in children/adolescents)
	• No symptom-free period for >2 months
	• Presence of ≥**2** of the following:
	  ◦ Poor appetite or overeating
	  ◦ Insomnia or hypersomnia
	  ◦ Low energy or fatigue
	  ◦ Low self-esteem
	  ◦ Poor concentration or difficulty making decisions
	  ◦ Feelings of hopelessness

Specifiers	• With **pure dysthymic syndrome**: criteria for major depressive episode never met • With intermittent major depressive episodes • With persistent major depressive episodes: criteria for major depressive episode met throughout previous 2 years

This patient's chronic depression, fatigue, and hopelessness are consistent with a diagnosis of persistent depressive disorder. Diagnosis requires **depressed mood** more days than not for **at least 2 years** (1 year in children) and at least 2 other depressive symptoms (Table). In DSM-5, persistent depressive disorder includes both "pure dysthymic syndrome" and chronic major depression or dysthymia with concurrent or intermittent major depressive episodes. This patient would be diagnosed with "pure dysthymic syndrome" as she has never met the criteria for a major depressive episode.

Diagnosis of persistent depressive disorder requires ruling out medical and substance-induced etiologies and differentiation from other psychiatric disorders. Persistent depressive disorder is treated with antidepressants, psychotherapy, or a combination of these.

(Choice A) Although this patient relates the onset of her depression to losing her job 4 years ago, her symptoms meet the criteria for persistent depressive disorder. Adjustment disorders are not diagnosed if criteria for another disorder are met. In adjustment disorder, symptoms occur within 3 months of the onset of the stressor(s) and do not persist for more than 6 months after the stressor or its consequences have terminated.

(Choice B) Patients with borderline personality disorder may experience intermittent depressive symptoms. This patient does not exhibit a

	• With persistent major depressive episodes: criteria for major depressive episode met throughout previous 2 years

This patient's chronic depression, fatigue, and hopelessness are consistent with a diagnosis of persistent depressive disorder. Diagnosis requires **depressed mood** more days than not for **at least 2 years** (1 year in children) and at least 2 other depressive symptoms (Table). In DSM-5, persistent depressive disorder includes both "pure dysthymic syndrome" and chronic major depression or dysthymia with concurrent or intermittent major depressive episodes. This patient would be diagnosed with "pure dysthymic syndrome" as she has never met the criteria for a major depressive episode.

Diagnosis of persistent depressive disorder requires ruling out medical and substance-induced etiologies and differentiation from other psychiatric disorders. Persistent depressive disorder is treated with antidepressants, psychotherapy, or a combination of these.

(Choice A) Although this patient relates the onset of her depression to losing her job 4 years ago, her symptoms meet the criteria for persistent depressive disorder. Adjustment disorders are not diagnosed if criteria for another disorder are met. In adjustment disorder, symptoms occur within 3 months of the onset of the stressor(s) and do not persist for more than 6 months after the stressor or its consequences have terminated.

(Choice B) Patients with borderline personality disorder may experience intermittent depressive symptoms. This patient does not exhibit a pervasive pattern of impulsivity and unstable mood, relationships, or self-image characteristic of borderline personality disorder.

(Choice C) The presence of depressive symptoms for more than 2 years rules out a diagnosis of major depressive disorder. Persistent depressive disorder can occur as a pure dysthymic syndrome, as in this patient, or with persistent or intermittent major depressive episodes.

(Choice E) Substance-induced mood disorder is diagnosed when depressive symptoms develop during or within a month of substance intoxication or withdrawal. This patient's urine screen is negative for substances, and the extent of her alcohol use would not explain her depressive symptoms.

Educational objective:
The DSM-5 diagnosis of persistent depressive disorder (dysthymia) is characterized by chronic depressed mood and at least 2 other depressive symptoms lasting for at least 2 years.

References

- Efficacy and acceptability of acute treatments for persistent depressive disorder: a network meta-analysis.
- DSM-5 and psychotic and mood disorders.

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A 16-year-old boy with suicidal thoughts is brought to the office by his parents. He has been in constant conflict with his parents since refusing to stop drinking alcohol, which he does on a daily basis. The patient is the oldest of 6 children; his mother suffers from lower back pain and relies on him for child care, which he finds overwhelming. His father works 2 jobs and is often not around to help with the children. His mother keeps a firearm by her bedside for protection when she is alone with the children at night. The patient dropped out of high school last year after getting dumped by his girlfriend. He recently contracted Lyme disease with resultant symptoms of fatigue and myalgia. Which of the following interventions is the best next step to decrease this patient's risk of completed suicide?

A. Advise the mother to lock away her firearm

B. Initiate treatment for depression

C. Provide the mother with assistance in the home

D. Start alcohol abuse counseling

E. Support the patient's return to high school

F. Treat the patient's Lyme disease

Submit

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- ✓ A. Advise the mother to lock away her firearm (73%)
- B. Initiate treatment for depression (8%)
- C. Provide the mother with assistance in the home (3%)
- D. Start alcohol abuse counseling (5%)
- E. Support the patient's return to high school (2%)
- F. Treat the patient's Lyme disease (6%)

Omitted
Correct answer
A

73%
Answered correctly

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03/06/2020
Last Updated

Explanation

Suicide risk & protective factors	
	• Psychiatric disorders, prior suicide attempts

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Suicide risk & protective factors	
Risk factors	• Psychiatric disorders, prior suicide attempts • Hopelessness • Never married, divorced, separated • Living alone • Elderly white man • Unemployed or unskilled • Physical illness • Family history of suicide, family discord • Access to firearms • Substance abuse, impulsivity
Protective factors	• Social support/family connectedness • Pregnancy • Parenthood • Religion & participation in religious activities

Suicide is a major public health issue that is linked to approximately 1 million deaths worldwide each year. It is the second leading cause of death, after accidents, in those aged 15-24. Suicide risk management involves controlling modifiable factors that decrease the risk of suicide, such as decreasing stress, improving psychosocial support, treating psychiatric illness and substance abuse, managing pain, and limiting **access to firearms** or other means of self-harm. Other risk factors are static and cannot be modified. These include age (teenagers and the elderly), male sex, family history of suicide, and history of previous attempts.

Individuals with access to firearms have 3 times the **risk** of **suicide completion**, as suicide by firearm is associated with a **higher fatality rate** compared to other methods. Due to the impulsivity often associated with suicide in teenagers, limiting this patient's access to firearms is the most important next step to decrease his risk.

(Choice B) Treatment for this patient's depression should be offered. However, the next step is to advise his mother to lock away her firearm, so

Suicide is a major public health issue that is linked to approximately 1 million deaths worldwide each year. It is the second leading cause of death, after accidents, in those aged 15-24. Suicide risk management involves controlling modifiable factors that decrease the risk of suicide, such as decreasing stress, improving psychosocial support, treating psychiatric illness and substance abuse, managing pain, and limiting **access to firearms** or other means of self-harm. Other risk factors are static and cannot be modified. These include age (teenagers and the elderly), male sex, family history of suicide, and history of previous attempts.

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(Choice B) Treatment for this patient's depression should be offered. However, the next step is to advise his mother to lock away her firearm, so that the risk of completed suicide is decreased while treatment takes effect.

(Choice C) Providing the mother with assistance could decrease the patient's burden in the long term but is not an immediate intervention.

(Choice D) Although alcohol use increases the risk for suicide by impairing judgment, this teenager does not acknowledge that he has an alcohol problem and may not be willing to start counseling at this time. Removing access to weapons is a more immediate measure.

(Choice E) Although decreasing this patient's isolation and improving his future prospects by helping him return to school is important in the long term, limiting access to firearms is the most pressing concern.

(Choice F) Chronic illness involving pain is a strong risk factor for attempted suicide. Although the patient's Lyme disease should be treated to prevent further disability, removal of access to firearms is more likely to prevent a completed suicide at this stage.

Educational objective:
Access to firearms greatly increases the risk of completed suicide. Evaluation of a patient's access to guns is a key part of suicide risk assessment. Other interventions to reduce suicide risk include decreasing stress, increasing psychosocial support, treating psychiatric illness and substance use, and managing pain.

References

- Firearm storage in gun-owning households with children: results of a 2015 national survey.

compared to other methods. Due to the impulsivity often associated with suicide in teenagers, limiting this patient's access to firearms is the most important next step to decrease his risk.

(Choice B) Treatment for this patient's depression should be offered. However, the next step is to advise his mother to lock away her firearm, so that the risk of completed suicide is decreased while treatment takes effect.

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Educational objective:
Access to firearms greatly increases the risk of completed suicide. Evaluation of a patient's access to guns is a key part of suicide risk assessment. Other interventions to reduce suicide risk include decreasing stress, increasing psychosocial support, treating psychiatric illness and substance use, and managing pain.

References

- Firearm storage in gun-owning households with children: results of a 2015 national survey.
- The accessibility of firearms and risk for suicide and homicide victimization among household members: a systematic review and meta-analysis.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Suicide
Subject	System	Topic

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A 45-year-old man is brought to the emergency department by police after locking himself in his office and refusing to come out. He believes that his business partner is trying to kill him. The patient's wife reports that he has been behaving in an increasingly unusual manner over the past year. She says, "He used to be outgoing and upbeat, but now he seems uncharacteristically depressed and distant from the family. He has lost interest in his work and has difficulty making decisions." Over the past month, he has become increasingly anxious and paranoid. The patient has no psychiatric history. His father and uncle both died in their 50s after being hospitalized in long-term institutional care facilities. Physical examination shows gait impairment characterized by random, abrupt, uncoordinated movements of the left leg. On mental status examination the patient is restless and irritable. He is convinced that not only his business partner but also the government is out to harm him. Which of the following is the most likely diagnosis?

- A. Brief psychotic disorder
- B. Delusional disorder
- C. Freidreich ataxia
- D. Huntington disease
- E. Major depression with psychotic features
- F. Parkinson disease
- G. Schizoaffective disorder
- H. Schizophrenia

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A. Brief psychotic disorder (1%)
B. Delusional disorder (3%)
C. Freidreich ataxia (4%)
✓ D. Huntington disease (64%)
E. Major depression with psychotic features (9%)
F. Parkinson disease (1%)
G. Schizoaffective disorder (5%)
H. Schizophrenia (10%)

Omitted
Correct answer
D

64%
Answered correctly

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Explanation

This patient's development of psychiatric symptoms in his mid-40s, abnormal choreiform movements (rapid and unpredictable contractions affecting mostly distal limbs), and family history are suggestive of **Huntington disease** (HD). HD is an autosomal dominant, progressive neurodegenerative disorder characterized by **chorea, psychiatric symptoms**, and subsequent **dementia**. Onset in mid-life is most common. There is no known cure and treatment is symptomatic.

Psychiatric symptoms are highly prevalent in HD and **may occur prior** to the onset of **chorea**. They may include irritability, anxiety, apathy, depression, and psychosis (eg, delusions, hallucinations). The dementia of HD develops later in the disease course and is characterized by prominent executive dysfunction. The diagnosis of HD is confirmed by testing for trinucleotide (cytosine-adenine-guanine [CAG]) repeat expansion in the huntingtin (*HTT*) gene.

(Choices A, B, and H) These are primary psychotic disorders that would not be diagnosed when psychosis is due to a medical condition. Brief psychotic disorder is characterized by ≥1 psychotic symptoms lasting ≥1 days and ≤1 month with full return to the previous level of functioning. Delusional disorder is characterized ≥1 delusions lasting ≥1 month. Schizophrenia typically has onset in young adulthood and is characterized by psychotic symptoms (eg, delusions, hallucinations, disorganization, negative symptoms) lasting ≥ 6 months.

(Choice C) Friedreich ataxia, the most common hereditary ataxia, is characterized by neurologic dysfunction, cardiomyopathy, and diabetes mellitus.

(Choices E and G) Although this patient has both mood and psychotic symptoms, they are more likely manifestations of HD. In major depression with psychotic features, psychosis occurs exclusively during the depression. In schizoaffective disorder, patients show evidence of psychosis when they are not depressed.

(Choice F) Parkinson disease (PD) is a progressive neurodegenerative disease characterized by tremor, bradykinesia, and rigidity. Psychosis can also occur in PD but typically presents later in the disease course. PD is less likely in this patient with early psychiatric findings, choreiform movements, and absence of other neurological findings of PD (eg, tremor, bradykinesia).

Educational objective:
Huntington Disease is an autosomal dominant, progressive neurodegenerative disorder characterized by chorea, psychiatric symptoms, and dementia. Psychiatric symptoms may occur early in the disease course and include irritability, anxiety, apathy, depression, and psychosis.

expansion in the huntingtin (*HTT*) gene.

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Educational objective:
Huntington Disease is an autosomal dominant, progressive neurodegenerative disorder characterized by chorea, psychiatric symptoms, and dementia. Psychiatric symptoms may occur early in the disease course and include irritability, anxiety, apathy, depression, and psychosis.

References

- Longitudinal psychiatric symptoms in prodromal Huntington's disease: a decade of data.
- Neuropsychiatric symptoms are very common in premanifest and early stage Huntington's disease.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Psychosis
Subject	System	Topic

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A 13-year-old boy is brought to the office by his parents after being involved in a fight with another student at school. His parents say, "He has never gotten into fights before, and we are getting worried because his grades have been declining as well. He seems irritable and moody, stays in his room for hours at a time, and no longer invites friends home." When interviewed alone about the incident, the patient says, "The wall people warned me that he was trying to poison my lunch." The patient has no significant medical history; there is a family history of bipolar disorder in a paternal aunt. Temperature is 37.2 C (99 F), blood pressure is 130/80 mm Hg, pulse is 98/min, and respirations are 14/min. Physical examination shows a postural tremor on extension of the arms and a broad-based gait. Mental status examination is significant for slurred speech, sad mood, and distractibility. Laboratory studies reveal elevated serum transaminases. Which of the following is the most likely diagnosis?

A. Acute intermittent porphyria
B. Alcohol abuse
C. Bipolar disorder with psychotic features
D. Hemochromatosis
E. Major depressive disorder with psychotic features
F. Prodromal schizophrenia
G. Wilson disease

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A. Acute intermittent porphyria (5%)

B. Alcohol abuse (12%)

C. Bipolar disorder with psychotic features (2%)

D. Hemochromatosis (5%)

E. Major depressive disorder with psychotic features (1%)

F. Prodromal schizophrenia (5%)

✓ G. Wilson disease (67%)

Omitted
Correct answer
G

67%
Answered correctly

02 secs
Time Spent

01/31/2020
Last Updated

Explanation

Wilson disease	
Pathogenesis	• Autosomal recessive mutation of *ATP7B* → hepatic copper accumulation → leak from damaged hepatocytes → deposits in tissues (eg, basal ganglia, cornea)
Clinical findings	• Hepatic (acute liver failure, chronic hepatitis, cirrhosis) • Neurologic (parkinsonism, gait disturbance, dysarthria) • Psychiatric (depression, personality changes, psychosis)
Diagnosis	• ↓ Ceruloplasmin & ↑ urinary copper excretion • Kayser-Fleischer rings on slit-lamp examination • ↑ Copper content on liver biopsy
Treatment	• Chelators (eg, D-penicillamine, trientine) • Zinc (interferes with copper absorption)

This patient's auditory hallucinations, mood and personality changes associated with neurologic features (slurred speech, tremor, gait instability), and abnormal liver function tests suggest a diagnosis of **Wilson disease**. Wilson disease is an autosomal recessive condition marked by **copper accumulation** in the liver, brain, and cornea, which most commonly manifests in childhood, adolescence, or early adulthood with hepatic involvement and/or neuropsychiatric symptoms.

Psychiatric symptoms range from subtle personality changes to depression, mania, and/or psychosis. These symptoms may predate **hepatic or neurologic manifestations** and be mistaken for normal adolescence or primary psychiatric illness. Evaluation includes a ceruloplasmin level, 24-hour urinary copper excretion, and slit-lamp examination for copper deposition in the cornea (Kayser-Fleischer rings).

(Choice A) Acute intermittent porphyria (AIP) can present with psychiatric symptoms; however, these are episodic in nature and normally associated with abdominal pain and peripheral neuropathy. AIP commonly manifests in midlife rather than childhood.

(Choice B) Heavy alcohol use can result in elevated transaminases and psychiatric symptoms, and acute intoxication can present with slurred

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(Choice B) Heavy alcohol use can result in elevated transaminases and psychiatric symptoms, and acute intoxication can present with slurred speech and unsteady gait. However, acute intoxication would likely present with stupor or disinhibition, alcohol on the breath, and additional findings such as abnormal vital signs (eg, hypotension, tachycardia), or other metabolic abnormalities (eg, hypoglycemia, hyperlactatemia). Tremors would be expected in alcohol withdrawal, not intoxication.

(Choices C and E) Although this patient has mood and psychotic symptoms, these primary psychiatric disorders would not explain his neurologic findings and abnormal liver function tests. Major depressive and bipolar disorders are not diagnosed when symptoms are attributable to another medical condition.

(Choice D) In hemochromatosis, there is an abnormal buildup of iron, which particularly affects the liver, heart, and pancreas. It may present with abnormal liver function tests, diabetes, arthralgia, and/or cardiomegaly. Hemochromatosis tends to present in later life (eg, age ≥ 40). Neurologic findings and psychosis are uncommon.

(Choice F) Prodromal schizophrenia often presents with personality changes and social withdrawal prior to the onset of overt psychosis. However, because primary psychotic disorders in children and adolescents are rare, a thorough workup of substance-induced and other etiologies is necessary. This patient's psychiatric symptoms are better explained as a manifestation of Wilson disease.

Educational objective:
Wilson disease is associated with copper accumulation in the liver, brain, and cornea. It can present in childhood or adolescence with abnormal liver function tests and/or neuropsychiatric symptoms. Psychiatric symptoms may predate other manifestations and include personality changes, depression, mania, and/or psychosis.

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Educational objective:
Wilson disease is associated with copper accumulation in the liver, brain, and cornea. It can present in childhood or adolescence with abnormal liver function tests and/or neuropsychiatric symptoms. Psychiatric symptoms may predate other manifestations and include personality changes, depression, mania, and/or psychosis.

References

- Wilson disease in children.
- Psychiatric aspects of Wilson disease: a review.
- Psychiatric manifestations in Wilson's disease: possibilities and difficulties for treatment.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Wilson disease
Subject	System	Topic

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A 52-year-old man comes to the office for follow-up to discuss the results of his colonoscopy. The physician informs the patient that a cancerous polyp was removed and that there is no evidence of invasive cancer at the resection margins. He is then reassured that he has an excellent prognosis. In response, the patient curses and shouts angrily, "Are you telling me I should be happy that you found cancer in the first place? You don't know what you're doing!" Which of the following is the most appropriate response to the patient?

A. "Feeling like you don't have control in your life can be difficult; I can assure you that you have received the best care."

B. "I realize it can be very upsetting to be told something unexpected about your health; what is your understanding of the results?"

C. "It's hard to process news like that, but I want to make sure you understand that the cancer was completely removed."

D. "You're allowed to feel angry, and I'm available to continue this conversation after you've calmed down."

E. "You seem very distressed with your results; would you like me to refer you to another physician for a second opinion?"

Submit

A 52-year-old man comes to the office for follow-up to discuss the results of his colonoscopy. The physician informs the patient that a cancerous polyp was removed and that there is no evidence of invasive cancer at the resection margins. He is then reassured that he has an excellent prognosis. In response, the patient curses and shouts angrily, "Are you telling me I should be happy that you found cancer in the first place? You don't know what you're doing!" Which of the following is the most appropriate response to the patient?

A. "Feeling like you don't have control in your life can be difficult; I can assure you that you have received the best care." (0%)

✓ B. "I realize it can be very upsetting to be told something unexpected about your health; what is your understanding of the results?" (89%)

C. "It's hard to process news like that, but I want to make sure you understand that the cancer was completely removed." (5%)

D. "You're allowed to feel angry, and I'm available to continue this conversation after you've calmed down." (4%)

E. "You seem very distressed with your results; would you like me to refer you to another physician for a second opinion?" (0%)

Omitted
Correct answer
B

89%
Answered correctly

02 secs
Time Spent

04/08/2020
Last Updated

Explanation

This patient is angry and verbally abusive after receiving an unexpected cancer diagnosis. Anxiety and distress likely exacerbate his sense of entitlement and demanding personality characteristics, and the physician must face the challenge of responding to his insulting comments. When patients are upset, they may have difficulty fully processing information. Instead, they may express anger at the physician rather than acknowledging their own fears.

The best approach is to defuse the situation by being **nondefensive** and **acknowledging the patient's anger**. This should be followed by an

Explanation

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The best approach is to defuse the situation by being **nondefensive** and **acknowledging the patient's anger**. This should be followed by an open-ended approach that **elicits** the **patient's understanding** about his condition and encourages him to express his **concerns** and fears about the diagnosis that likely underlie his behavior.

(Choice A) This statement initially expresses empathy but then assumes a defensive stance, which is unlikely to engage the patient or defuse his anger.

(Choice C) This statement assumes that the patient did not understand the information provided, which may be perceived as judgmental. The best initial approach is to acknowledge the patient's anger while exploring his understanding of the results. Reassurance that the cancer was removed would be the appropriate next step if discussion revealed that he misunderstood his prognosis.

(Choice D) Suggesting that the patient should calm down is likely to be perceived as condescending and judgmental, leading to further deterioration of rapport.

(Choice E) Suggesting referral to another provider may be perceived as an attempt to get rid of the patient. The first step should be to defuse the patient's anger and attempt to preserve the physician-patient relationship.

Educational objective:
When confronting an angry patient, the physician should use a nondefensive, empathic approach that acknowledges the patient's anger and attempts to explore the patient's underlying concerns.

References

- Defusing the angry patient: 25 tips.

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References

- Defusing the angry patient: 25 tips.
- Evaluation and treatment of the angry patient.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Physician patient communication
Subject	System	Topic

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A 35-year-old woman comes to the office due to worsening fatigue and tension headaches over the past year. She describes always feeling "on edge" and lies awake at night worrying about various issues such as whether she is good at her job, whether her grown children like her, if she will get cancer one day, and whether her house will be broken into. During the day she feels tired and her shoulders and neck ache; she has difficulty concentrating on her work and has become increasingly concerned about losing her job. The patient has no medical or psychiatric history. Physical examination and routine laboratory studies, including thyroid function tests, are normal. The patient's anxiety has never been treated, but she once took a tablet of alprazolam offered by a friend. This lowered her anxiety, but the effect did not last long. The patient drinks a glass of wine on rare social occasions and does not use illicit drugs. Which of the following is the most appropriate pharmacotherapy for this patient?

A. Alprazolam
B. Bupropion
C. Citalopram
D. Clonazepam
E. Diazepam
F. Propranolol

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- A. Alprazolam (2%)
- B. Bupropion (12%)
- ✓ C. Citalopram (62%)
- D. Clonazepam (6%)
- E. Diazepam (14%)
- F. Propranolol (2%)

Omitted
Correct answer
C

62%
Answered correctly

02 secs
Time Spent

02/25/2020
Last Updated

Explanation

This patient's excessive and chronic worry, feeling on edge, muscle tension, and insomnia are characteristic of generalized anxiety disorder (GAD). Patients with GAD have multiple worries about everyday issues (eg, work, health, finances, safety of family members) that cause

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Explanation

This patient's excessive and chronic worry, feeling on edge, muscle tension, and insomnia are characteristic of generalized anxiety disorder (GAD). Patients with GAD have multiple worries about everyday issues (eg, work, health, finances, safety of family members) that cause significant distress and functional impairment. GAD is treated with **cognitive behavioral psychotherapy** and/or antidepressant medication. Selective serotonin reuptake inhibitors **(SSRIs)** such as citalopram or serotonin-norepinephrine reuptake inhibitors **(SNRIs)** are **first-line treatment**. This patient's insomnia should improve as the medication takes effect and her anxiety decreases.

Although this patient experienced acute relief with alprazolam, benzodiazepines are less preferred in the treatment of chronic anxiety. Benzodiazepines (eg, alprazolam, clonazepam, diazepam) are considered second-line therapy due to the risks of dependence and tolerance, and the potential for rebound and withdrawal syndromes with abrupt discontinuation **(Choices A, D, and E)**. Benzodiazepines can be used on a limited basis to manage acute anxiety while waiting for SSRIs or SNRIs to take effect. However, they should be avoided in patients with a history of substance use disorder.

(Choice B) Bupropion is a norepinephrine dopamine reuptake inhibitor approved for the treatment of major depressive disorder and smoking cessation. It is not a first-line agent for GAD and may worsen symptoms due to its activating effects. Bupropion should not be confused with buspirone, a non-benzodiazepine anxiolytic that is another second-line treatment option for GAD.

(Choice F) Propranolol, a beta-adrenergic blocker, can be used as needed for the performance subtype of social anxiety disorder and in the prophylactic treatment of migraine headaches. Beta blockers are not a first-line treatment for GAD. This patient's headaches are related to muscle tension, which should improve as her anxiety is treated.

Educational objective:
Serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors are first-line medications for generalized anxiety disorder. Benzodiazepines should be limited to short-term use while antidepressants take effect and avoided in patients with a history of substance abuse.

References

- Pharmacotherapy of generalized anxiety disorder.
- Pharmacotherapy for generalized anxiety disorder in adult and pediatric patients: an evidence-based treatment review.

Explanation

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(GAD). Patients with GAD
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prophylactic treatment of
muscle tension, which sho

Educational objective:
Serotonin reuptake inhibit
Benzodiazepines should b

References

- Pharmacotherapy of g
- Pharmacotherapy for

Exhibit Display

Generalized anxiety disorder	

Clinical features	• Excessive, uncontrollable worry (multiple issues) ≥6 months
	• ≥3 of the following symptoms:
	  ◦ Restlessness; feeling on edge
	  ◦ Fatigue
	  ◦ Difficulty concentrating
	  ◦ Irritability
	  ◦ Muscle tension
	  ◦ Sleep disturbance

Treatment	• Cognitive-behavioral therapy • SSRIs or SNRIs

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

Add To New Card | Existing Card

A 42-year-old man comes to the office for a checkup. He has no medical symptoms but says, "I'm just feeling stressed and not like myself." The patient is going through a contentious divorce. He is outraged that his wife is pursuing full custody of their children and says, "I can't believe she is doing this to me." His job as a legal researcher had been a welcome distraction from his upsetting personal life until yesterday when he was called to his supervisor's office for yelling at the receptionist when the copy machine ran out of ink. Which of the following is the best explanation for this patient's behavior toward the receptionist?

- A. Acting out
- B. Denial
- C. Displacement
- D. Intellectualization
- E. Reaction formation
- F. Splitting
- G. Sublimation

Submit

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- A. Acting out (5%)
- B. Denial (0%)
- ✓ C. Displacement (90%)
- D. Intellectualization (0%)
- E. Reaction formation (1%)
- F. Splitting (0%)
- G. Sublimation (0%)

Omitted
Correct answer
C

90%
Answered correctly

03 secs
Time Spent

07/06/2020
Last Updated

Explanation

Key defense mechanisms	

Key defense mechanisms	
Immature	• Acting out: Expressing unacceptable feelings through actions • Denial: Behaving as if an aspect of reality does not exist • Displacement: Transferring feelings to less threatening object/person • Intellectualization: Focusing on nonemotional aspects to avoid distressing feelings • Passive aggression: Avoiding conflict by expressing hostility covertly • Projection: Attributing one's own feelings to others • Rationalization: Justifying behavior to avoid difficult truths • Reaction formation: Transforming unacceptable feelings/impulses into the opposite • Regression: Reverting to earlier developmental stage • Splitting: Experiencing a person/situation as either all positive or all negative
Mature	• Sublimation: Channeling impulses into socially acceptable behaviors • Suppression: Putting unwanted feelings aside to cope with reality

This patient's redirection of his anger from his wife to the receptionist is an example of the defense mechanism **displacement**. In displacement, **emotions** are unconsciously **transferred** from their actual target **to someone** or something else that is **less threatening**. In this case, the patient is angry with his wife but cannot express it directly as it may impact the child custody proceedings. Instead, he unconsciously transfers the emotion to the receptionist, resulting in his angry outburst over a minor incident.

(Choice A) Acting out refers to the expression of unacceptable thoughts or impulses through actions (eg, if this patient were to react to his wife's pursuit of full custody by vandalizing her car).

(Choice B) In denial, an individual avoids awareness of external realities that are difficult to face (eg, if this patient were to insist that his marriage is conflict-free).

(Choice D) In intellectualization, an individual focuses on nonemotional aspects of a distressing situation to make it more tolerable (eg, if this patient were solely preoccupied with thinking about the legal, not the emotional, aspects of his divorce).

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(Choice E) Reaction formation involves transforming unacceptable feelings into their opposite (eg, if this patient, who is angry at his wife, were to act in an overly loving manner toward her).

(Choice F) Splitting involves experiencing the self or others in extremes, either all positive or all negative, which allows "bad" qualities to be completely separated from the "good" (eg, if this patient were to view his wife as a horrible person with no redeeming qualities).

(Choice G) Sublimation involves transforming unacceptable impulses into socially acceptable behaviors (eg, if this patient were to take up boxing as a means of venting frustration).

Educational objective:
In displacement, emotions are transferred from the person causing the negative emotions to a more neutral, less threatening person or object.

References

- Change in coping and defense mechanisms across adulthood: longitudinal findings in a European American sample.
- Understanding defense mechanisms.

Behavioral science Psychiatric/Behavioral & Substance Abuse Defense mechanisms

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Behavioral science	Psychiatric/Behavioral & Substance Abuse	Defense mechanisms
Subject	System	Topic

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A 14-year-old boy is brought to the office by his mother for a 6-month checkup for asthma. Although the patient's asthma is generally well controlled with long-acting agents, he has episodes of exercise-induced bronchoconstriction for which he was prescribed a short-acting beta agonist. His mother became concerned after the physical education teacher called from school saying that her son was refusing to participate in class. When asked about this, the patient said that it was easier to avoid exercising than to use an inhaler at school. Family history is significant for chronic obstructive pulmonary disease (COPD) in his maternal grandfather, heart disease in his father, and generalized anxiety disorder in his mother. Vital signs and physical examination are within normal limits. Which of the following factors would most likely increase this patient's adherence with bronchodilator administration?

A. Receiving education about the association between asthma and COPD

B. Receiving online resources about successful athletes who have asthma

C. Receiving counsel from the physician that inhaler use before exercise prevents asthma symptoms

D. Receiving written material about the benefits of exercise in long-term asthma management

E. Seeing peers use asthma inhalers at school

F. Understanding that his mother is very concerned about his behavior

Submit

A 14-year-old boy is brought to the office by his mother for a 6-month checkup for asthma. Although the patient's asthma is generally well controlled with long-acting agents, he has episodes of exercise-induced bronchoconstriction for which he was prescribed a short-acting beta agonist. His mother became concerned after the physical education teacher called from school saying that her son was refusing to participate in class. When asked about this, the patient said that it was easier to avoid exercising than to use an inhaler at school. Family history is significant for chronic obstructive pulmonary disease (COPD) in his maternal grandfather, heart disease in his father, and generalized anxiety disorder in his mother. Vital signs and physical examination are within normal limits. Which of the following factors would most likely increase this patient's adherence with bronchodilator administration?

- A. Receiving education about the association between asthma and COPD (1%)
- B. Receiving online resources about successful athletes who have asthma (9%)
- C. Receiving counsel from the physician that inhaler use before exercise prevents asthma symptoms (14%)
- D. Receiving written material about the benefits of exercise in long-term asthma management (3%)
- ✓ E. Seeing peers use asthma inhalers at school (70%)
- F. Understanding that his mother is very concerned about his behavior (0%)

Omitted
Correct answer
E

70%
Answered correctly

01 sec
Time Spent

01/20/2020
Last Updated

Explanation

Adolescence involves the developmental tasks of separating from parental figures and finding one's own place in society, which includes beginning to take responsibility for one's physical health. This exploration is often accompanied by rebelling, pushing limits, and having a strong

Explanation

Adolescence involves the developmental tasks of separating from parental figures and finding one's own place in society, which includes beginning to take responsibility for one's physical health. This exploration is often accompanied by rebelling, pushing limits, and having a strong need to fit in with a peer group, all factors that may contribute to low treatment adherence rates. In particular, adolescents with chronic medical conditions may hide their illness due to feeling self-conscious and different from their peers. Factors associated with **better treatment adherence** rates include close **peers with complementary behavioral practices**, positive family functioning, school involvement, physician empathy, and immediate benefits of treatment.

Another factor affecting adolescent treatment adherence is that the prefrontal cortex (center of executive function) does not fully develop until the third decade of life. Compared to adults, adolescents are less able to weigh the risks and benefits of their decisions or to anticipate that negative consequences may occur.

(Choices A and D) Although education and written instruction are important in increasing adherence, adolescents struggle to conceive of possibilities outside their immediate experience and do not anticipate negative consequences happening to them. The desire to improve long-term asthma symptoms or to prevent chronic obstructive pulmonary disease is unlikely to be a major motivating factor.

(Choice B) Although learning about role models (eg, famous athletes) with asthma might be helpful, similar peer behavior is more likely to decrease this patient's embarrassment about using an inhaler in the school setting.

(Choice C) Physician education about the patient's illness is unlikely to be as strong a factor in adherence as peer acceptance. As adolescents strive to become more independent, they may rebel against authority figures, including physicians.

(Choice F) Although parental attitudes and support are important in helping adolescents maintain adherence, making the patient feel responsible for causing his mother's concern is inappropriate and unlikely to facilitate adherence.

Educational objective:
Adolescents have low treatment adherence rates due to issues with autonomy, rebellion against authority, increased self-consciousness, and a lack of understanding of potential risks. Peer behavior has a strong influence on adherence due to adolescents' desire to fit in with their social groups.

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References

- [Adolescence and asthma management: the perspective of adolescents receiving primary health care].
- The adolescent with asthma.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Adolescent adherence
Subject	System	Topic

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A 32-year-old man is diagnosed with major depressive disorder and started on the selective serotonin reuptake inhibitor sertraline. At his 2-week follow-up, the patient reports that his mood is "about the same." He continues to feel sad and unmotivated most days and is short-tempered with his wife and kids. He has little interest in food, sleeps poorly, and struggles to stay focused at work. In the first 2-3 days of taking the medication, the patient experienced some mild nausea and anxiety that has since resolved. He is now tolerating the medication without difficulty but is considering stopping it because he is discouraged by the lack of clear improvement. Which of the following is the most likely explanation for this patient's lack of response?

A. Comorbid anxiety disorder
B. Development of tolerance
C. Inadequate duration of treatment
D. Medication side effect
E. Poor treatment adherence
F. Treatment-resistant depression

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- A. Comorbid anxiety disorder (0%)
- B. Development of tolerance (0%)
- ✓ C. Inadequate duration of treatment (92%)
- D. Medication side effect (0%)
- E. Poor treatment adherence (2%)
- F. Treatment-resistant depression (3%)

Omitted
Correct answer
C

92%
Answered correctly

02 secs
Time Spent

01/29/2020
Last Updated

Explanation

This patient has classic symptoms of major depressive disorder (eg, depressed mood, loss of interest, sleep and appetite disturbance, impaired concentration) and is being treated appropriately with the selective serotonin reuptake inhibitor (SSRI) sertraline. As a drug class, antidepressants are associated with an interval delay between drug initiation and clinical response. At this point, the most likely explanation for this patient's poor

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An **adequate antidepressant trial** is generally considered to be at least **4-6 weeks**, so lack of significant improvement at the 2-week mark is not uncommon. The patient should be encouraged to continue taking the medication for at least 2-4 more weeks before the next step in treatment is considered.

(Choices A and D) Anxiety and nausea are common early side effects of SSRIs and typically resolve over time without intervention, as in this patient. This patient is now tolerating the medication well.

(Choice B) Tolerance refers to diminished response to a drug with repeated use. This patient has not yet developed an effective therapeutic response.

(Choice E) Difficulties with medication adherence should always be considered in a patient who is not responding to medication. However, this patient discloses that he is thinking about stopping the medication; therefore, there is no reason to suspect that he has already done so.

(Choice F) Treatment-resistant depression is commonly defined as failure to respond to at least 2 adequate antidepressant trials. This patient cannot be considered treatment resistant because he has had an inadequate trial of a single medication.

Educational objective:
Antidepressants (eg, selective serotonin reuptake inhibitors) take 4-6 weeks to achieve maximal clinical effect.

References

- Evaluating antidepressant treatment prior to adding second-line therapies among patients with treatment-resistant depression.
- When should you move beyond first-line therapy for depression?

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Antidepressants
Subject	System	Topic

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Behavioral science	Psychiatric/Behavioral & Substance Abuse	Antidepressants
Subject	System	Topic

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C. Inadequate duration of treatment (92%)

D. Medication s

E. Poor treatme

F. Treatment-re

Omitted
Correct answer
C

Explanation

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concentration) and is bein
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Exhibit Display

Major depressive disorder	
Diagnosis	• ≥5 of the following symptoms lasting ≥2 weeks (at least 1 symptom must be either depressed mood or loss of interest/pleasure): ◦ Depressed mood ◦ Loss of interest or pleasure ◦ Change in appetite or weight ◦ Insomnia or hypersomnia ◦ Psychomotor retardation or agitation ◦ Low energy ◦ Poor concentration or indecisiveness ◦ Thoughts of worthlessness or inappropriate guilt ◦ Recurrent thoughts of death or suicide • No history of mania or hypomania • Not due to substances or another medical condition
Treatment	• Psychotherapy • Antidepressant medication

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An 83-year-old woman is sent to the emergency department from the nursing home where she resides for evaluation of mental status changes. At baseline, she has mild memory impairment but is otherwise cognitively intact, calm, and cooperative with the nursing home staff. Over the past 24 hours, she has become increasingly combative and agitated and stayed up all night. Behavioral interventions and environmental modifications have not been helpful. The patient's medical conditions include hypertension and a history of anxiety and depression. Temperature is 37.2 C (99 F), blood pressure is 110/80 mm Hg, pulse is 84/min, and respirations are 18/min. Neurological examination is normal, but the patient is unable to attend to the conversation, is mildly disoriented, and cannot state the days of the week backwards. Without provocation, she strikes out at a nurse's aide standing next to her. Laboratory results are normal except for urinalysis, which shows an increased presence of white blood cells and is positive for nitrites. Head CT scan is negative. In addition to starting antibiotic therapy, which of the following medications is most appropriate to treat this patient's behavioral symptoms?

A. Clozapine
B. Doxepin
C. Haloperidol
D. Lithium
E. Lorazepam
F. Temazepam

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A. Clozapine (8%)
B. Doxepin (6%)
✓ C. Haloperidol (47%)
D. Lithium (5%)
E. Lorazepam (27%)
F. Temazepam (4%)

Omitted
Correct answer
C

47%
Answered correctly

02 secs
Time Spent

02/16/2020
Last Updated

Explanation

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Explanation

Delirium is an acute-onset "confusional state" characterized primarily by **waxing and waning mental status** changes and impaired attention. Disorientation, agitation, psychosis, and sleep disturbances may also occur. Delirium occurs secondary to an underlying medical condition, such as a urinary tract infection, and therefore the primary management is **treating the underlying cause**. The elderly and those with preexisting cognitive disorders are at a higher risk for delirium and may present with varying degrees of agitation.

High-potency, first-generation antipsychotics (eg, **haloperidol**) and some second-generation antipsychotics (eg, quetiapine) can be used for the acute **treatment of agitation and psychosis** associated with delirium. Antipsychotic use is appropriate in the treatment of delirium in the elderly if the patient is at **risk of acute harm** to self or others and behavioral interventions have failed. Under these conditions, the benefits of antipsychotics (ie, the provision of safety) outweigh the potential risks when used at low doses and short durations.

(Choice A) Clozapine is a second-generation antipsychotic that is reserved for patients with treatment-refractory schizophrenia. It is not used for the short-term treatment of agitation in delirium due to the risk of agranulocytosis.

(Choice B) Doxepin is a tricyclic antidepressant with anticholinergic effects that can worsen delirium. It may be used for the treatment of insomnia in other settings.

(Choice D) Lithium is a mood stabilizer. It is not used for the short-term treatment of behavioral dyscontrol in nonmanic patients.

(Choices E and F) Benzodiazepines (eg, lorazepam, temazepam) can worsen confusional states, particularly in the elderly. Benzodiazepines are appropriate only for the treatment of delirium due to alcohol or benzodiazepine withdrawal.

Educational objective:
Delirium may manifest as acute changes in cognition and behavior. When nonpharmacological interventions are ineffective, low-dose antipsychotics (eg, haloperidol) are the medications of choice to treat the behavioral (eg, severe agitation) and psychotic manifestations of delirium.

References

- Delirium and its treatment.
- Atypical antipsychotics for the treatment of ICU delirium.

cognitive disorders are at a higher risk for delirium and may present with varying degrees of agitation.

High-potency, first-generation antipsychotics (eg, **haloperidol**) and some second-generation antipsychotics (eg, quetiapine) can be used for the acute **treatment of agitation and psychosis** associated with delirium. Antipsychotic use is appropriate in the treatment of delirium in the elderly if the patient is at **risk of acute harm** to self or others and behavioral interventions have failed. Under these conditions, the benefits of antipsychotics (ie, the provision of safety) outweigh the potential risks when used at low doses and short durations.

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Educational objective:
Delirium may manifest as acute changes in cognition and behavior. When nonpharmacological interventions are ineffective, low-dose antipsychotics (eg, haloperidol) are the medications of choice to treat the behavioral (eg, severe agitation) and psychotic manifestations of delirium.

References

- Delirium and its treatment.
- Atypical antipsychotics for the treatment of ICU delirium.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Delirium
Subject	System	Topic

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A 26-year-old man is hospitalized after he was found in the park shouting and laughing to himself. He insists on wearing a cap lined with several layers of aluminum foil and explains that the hat prevents laser beams from reprogramming his mind. For the past 3 years, the patient has been hearing the voices of his deceased mother, the devil, and a world-famous singer. He has had one previous psychiatric hospitalization, during which he responded well to haloperidol. However, the patient stopped the medication shortly after discharge because he did not like the way it made him feel. A decision is made to administer a second-generation antipsychotic medication. Compared with first-generation antipsychotics, this class of medication is associated with which of the following?

A. Greater efficacy in the treatment of positive psychotic symptoms
B. Greater risk of anticholinergic effects
C. Greater risk of tardive dyskinesia
D. Lower risk of acute dystonia
E. Lower risk of metabolic adverse effects
F. Lower risk of seizures

Submit

A 26-year-old man is hospitalized after he was found in the park shouting and laughing to himself. He insists on wearing a cap lined with several layers of aluminum foil and explains that the hat prevents laser beams from reprogramming his mind. For the past 3 years, the patient has been hearing the voices of his deceased mother, the devil, and a world-famous singer. He has had one previous psychiatric hospitalization, during which he responded well to haloperidol. However, the patient stopped the medication shortly after discharge because he did not like the way it made him feel. A decision is made to administer a second-generation antipsychotic medication. Compared with first-generation antipsychotics, this class of medication is associated with which of the following?

- A. Greater efficacy in the treatment of positive psychotic symptoms (8%)
- B. Greater risk of anticholinergic effects (8%)
- C. Greater risk of tardive dyskinesia (3%)
- ✓ D. Lower risk of acute dystonia (69%)
- E. Lower risk of metabolic adverse effects (5%)
- F. Lower risk of seizures (3%)

Omitted
Correct answer
D

69%
Answered correctly

01 sec
Time Spent

03/02/2020
Last Updated

Explanation

Common antipsychotic side effects	
	High-potency (eg, haloperidol)

Common antipsychotic side effects	
First-generation antipsychotics (FGAs)	**High-potency** (eg, haloperidol) • Extrapyramidal symptoms (acute dystonia, akathisia, parkinsonism), tardive dyskinesia **Low-potency** (eg, chlorpromazine) • Sedation, cholinergic blockade, orthostatic hypotension, weight gain
Second-generation antipsychotics (SGAs)	• Metabolic syndrome, weight gain • Extrapyramidal symptoms (less common than FGAs)

This patient is experiencing an acute psychotic episode (delusions, hallucinations, disorganized behavior) most likely due to schizophrenia, a chronic psychotic illness with typical onset in young adulthood. His treatment history indicates a good response to the **first-generation antipsychotic** (FGA) haloperidol but poor adherence, likely because of tolerability issues. As a class, FGAs are associated with a **high risk of extrapyramidal symptoms** (EPSs) due to their potent D2 antagonism. Types of EPS effects include acute dystonic reactions, drug-induced parkinsonism, akathisia (inner restlessness and inability to sit still), and tardive dyskinesia.

Second-generation antipsychotics (SGAs) are often used for first-line treatment in schizophrenia due to their **lower risk of EPSs** compared with FGAs. However, SGAs are associated with **weight gain** and **metabolic effects**, including the development of **diabetes**. Side effect profiles of individual SGAs vary; olanzapine and clozapine are associated with the greatest risk of metabolic effects.

(Choice A) FGAs and SGAs appear to be equally effective in the treatment of positive psychotic symptoms.

(Choice B) Both FGAs and SGAs block muscarinic receptors to varying degrees. Low-potency FGAs (eg, chlorpromazine) and the SGAs olanzapine, quetiapine, and clozapine have the greatest risk.

(Choice C) SGAs are less likely to cause tardive dyskinesia than FGAs.

(Choice E) Compared with FGAs, SGAs have a greater risk of metabolic adverse effects.

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(Choice C) SGAs are less likely to cause tardive dyskinesia than FGAs.

(Choice E) Compared with FGAs, SGAs have a greater risk of metabolic adverse effects.

(Choice F) Both FGAs and SGAs have been associated with lowering the seizure threshold. The SGA clozapine, in particular, has been associated with a dose-dependent increase in seizure risk.

Educational objective:
Second-generation antipsychotics are associated with a lower risk of extrapyramidal side effects compared with first-generation antipsychotics but may cause adverse metabolic effects.

References

- Second-generation antipsychotics and extrapyramidal adverse effects.
- Atypical antipsychotics: A review on the prevalence, monitoring, and management of their metabolic and cardiovascular side effects.

Behavioral science Psychiatric/Behavioral & Substance Abuse Schizophrenia

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A 27-year-old man is brought to the emergency department by his roommate, who found the patient barricading himself in a closet at home and saying, "They're coming to get me. No one can be trusted." The patient was laid off from his job and broke up with his girlfriend last month. He has heard voices threatening to kill him a few times daily for the past 2 weeks. He has no medical or psychiatric history and does not use alcohol or illicit drugs. Physical examination and laboratory results are unremarkable. On mental status examination, the patient is fearful and tense. He describes being followed by men in black cars who are spying on him. Which of the following is the most likely diagnosis in this patient?

A. Acute stress disorder
B. Bipolar disorder with psychotic features
C. Brief psychotic disorder
D. Delusional disorder
E. Paranoid personality disorder
F. Schizophrenia
G. Schizophreniform disorder
H. Schizotypal personality disorder

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A. Acute stress disorder (1%)
B. Bipolar disorder with psychotic features (0%)
✓ C. Brief psychotic disorder (64%)
D. Delusional disorder (3%)
E. Paranoid personality disorder (2%)
F. Schizophrenia (3%)
G. Schizophreniform disorder (21%)
H. Schizotypal personality disorder (0%)

Omitted
Correct answer
C

64%
Answered correctly

06 secs
Time Spent

02/06/2020
Last Updated

Explanation

Differential diagnosis of DSM-5 psychotic disorders	
Brief psychotic disorder	**≥1 days & <1 month**, sudden onset, full return to function
Schizophreniform disorder	**≥1 months & <6 months**, same symptoms as schizophrenia, functional decline not required
Schizophrenia	**≥6 months** (includes ≥1 months of active symptoms, can include prodromal & residual periods), requires functional decline
Schizoaffective disorder	Mood episode with concurrent active-phase symptoms of schizophrenia + ≥2 weeks of delusions or hallucinations in the absence of prominent mood symptoms
Delusional disorder	**≥1 delusions & ≥1 months**, **no other psychotic symptoms**, normal functioning apart from direct impact of delusions

This patient's 2-week history of hearing voices and paranoid delusions is consistent with **brief psychotic disorder**. Onset is typically sudden in response to an overwhelming stressor. Diagnosis requires **≥1 psychotic symptoms** (ie, delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) lasting **>1 day and <1 month** with eventual return to premorbid functioning. The diagnosis requires ruling out psychosis secondary to a mood disorder and psychosis due to substances or a medical condition.

Symptom duration is a key feature in differentiating brief psychotic disorder from other psychotic disorders. If this patient's symptoms were to continue for >1 month but <6 months, the diagnosis of schizophreniform disorder would be indicated **(Choice G)**. If the symptoms were to continue for ≥6 months, the accurate diagnosis would be schizophrenia **(Choice F)**.

(Choice A) Acute stress disorder is characterized by symptoms of intrusion (eg, flashbacks), negative mood, dissociation, avoidance, and arousal that occur in the initial month after exposure to a life-threatening traumatic event.

(Choice B) Bipolar disorder can present with psychotic features; however, this patient lacks other characteristic manic symptoms (eg, elated mood, increased energy, pressured speech, decreased need for sleep, grandiosity).

disorganized or catatonic behavior) lasting **>1 day and <1 month** with eventual return to premorbid functioning. The diagnosis requires ruling out psychosis secondary to a mood disorder and psychosis due to substances or a medical condition.

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(Choice A) Acute stress disorder is characterized by symptoms of intrusion (eg, flashbacks), negative mood, dissociation, avoidance, and arousal that occur in the initial month after exposure to a life-threatening traumatic event.

(Choice B) Bipolar disorder can present with psychotic features; however, this patient lacks other characteristic manic symptoms (eg, elated mood, increased energy, pressured speech, decreased need for sleep, grandiosity).

(Choice D) Delusional disorder is characterized by ≥1 delusions lasting ≥1 months and would not explain this patient's prominent hallucinations.

(Choices E and H) Personality disorders are characterized by enduring patterns of behavior. Patients with paranoid personality disorder are generally suspicious and distrustful. Schizotypal personality disorder is characterized by odd thinking and eccentric behavior, but not frank psychosis. Neither disorder would explain this patient's acute onset of delusions and hallucinations.

Educational objective:
Brief psychotic disorder is characterized by ≥1 psychotic symptoms lasting >1 day and <1 month with full return to previous levels of functioning. Onset is typically sudden and associated with a stressor.

References

- Structure of the psychotic disorders classification in DSM-5.
- Prognosis of brief psychotic episodes: a meta-analysis.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Psychosis
Subject	System	Topic

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An 8-year-old boy is brought to the pediatrician for school refusal. He has not gone to school for a few days, saying that he has a stomachache. However, when it comes time for soccer practice, he has no physical symptoms. When the pediatrician asks how things are going at school, the patient says, "kids laughed at me when the teacher said she couldn't read my homework." His mother brings a recent report from the boy's teacher, which says that he is able to read and do math, but that when writing he fidgets a lot and stares out the window. His writing is unclear, disorganized, and below the level of his peers. His mother received a call from his teacher last week after the boy threw his writing book on the floor and began to cry. Vital signs and physical examination, including abdominal examination, are normal. At this time, which of the following is the most likely diagnosis in this patient?

A. Attention-deficit hyperactivity disorder
B. Language disorder
C. Mild intellectual disability
D. Oppositional defiant disorder
E. Social anxiety disorder
F. Somatic symptom disorder
G. Specific learning disorder

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A. Attention-deficit hyperactivity disorder (12%)
B. Language disorder (4%)
C. Mild intellectual disability (2%)
D. Oppositional defiant disorder (1%)
E. Social anxiety disorder (3%)
F. Somatic symptom disorder (3%)
✓ G. Specific learning disorder (72%)

Omitted
Correct answer
G

72%
Answered correctly

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Explanation

A learning disorder is characterized by difficulties with key academic skills (reading, writing, or mathematics). Problems manifest at school

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A **learning disorder** is characterized by **difficulties** with key **academic skills** (**reading**, **writing**, or **mathematics**). Problems manifest at school age when these skills are being acquired, and performance is well below average for age. Many children display symptoms of anxiety, inattention, defiance, or hyperactivity when under stress to perform in an area of weakness, as exemplified by this child's struggle to pay attention and his emotional outburst in class. Learning disorders are often comorbid (eg, writing plus reading). In addition to academic dysfunction, they can also impact social skills and self-confidence.

Definitive diagnosis requires comprehensive assessment, including educational testing and ruling out intellectual disability, hearing or vision impairment, and other psychiatric or neurological disorders. Providers should consider the possibility of a learning disorder in any child presenting with **school difficulty**. Early intervention can be helpful in improving self-esteem and preventing further disability.

(Choice A) Attention-deficit hyperactivity disorder is characterized by inattention and/or hyperactivity-impulsivity across at least 2 settings. There is no indication that this child struggles with inattention or hyperactivity when asked to read or do math or that this is a problem in the home setting.

(Choice B) Language disorder presents with difficulties in acquiring and using language, which manifests in speaking as well as written language.

(Choice C) Intellectual disability begins in early development and includes deficits in general mental abilities and adaptive functioning. Specific learning disorders occur in the presence of normal levels of intellectual functioning.

(Choice D) In oppositional defiant disorder, there is a pattern of anger or irritability, argumentativeness, and defiant behavior. This patient's school refusal and throwing a book are in the context of stress. There is no indication that he is routinely defiant or argumentative.

(Choice E) This patient enjoys playing soccer, and his school refusal is more likely due to fears of being teased. A diagnosis of social anxiety disorder requires persistent symptoms ≥6 months. This boy's learning disorder should be addressed to avoid further social anxiety.

(Choice F) In somatic symptom disorder, anxiety revolves around a patient's symptoms. This boy is not anxious about his stomachache; his stomachache is a manifestation of his anxiety about school.

Educational objective:
Learning disorders are characterized by difficulties with key academic skills (reading, writing, or mathematics), resulting in performance well below expectations for age. Providers should consider a possible learning disorder in any school-aged child with behavioral, academic, or social difficulties at school.

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is no indication that this child struggles with inattention or hyperactivity when asked to read or do math or that this is a problem in the home setting.

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(Choice F) In somatic symptom disorder, anxiety revolves around a patient's symptoms. This boy is not anxious about his stomachache; his stomachache is a manifestation of his anxiety about school.

Educational objective:
Learning disorders are characterized by difficulties with key academic skills (reading, writing, or mathematics), resulting in performance well below expectations for age. Providers should consider a possible learning disorder in any school-aged child with behavioral, academic, or social difficulties at school.

References

- Critical issues in the understanding of young elementary school students at risk for problems in written expression: introduction to the special series.
- Specific learning disorder: prevalence and gender differences.
- Specific learning disorders and ADHD: current issues in diagnosis across clinical and educational settings.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Learning disorders
Subject	System	Topic

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A 35-year-old woman comes to the office due to insomnia and fatigue over the past month. She has felt increasingly depressed, irritable, and worthless since being let go from her job 5 weeks ago. The week prior to her last menstrual period was particularly difficult, and she stayed in bed most of the day. Over the last month, the patient has lost 3.6 kg (8 lb) and has felt unmotivated and unable to concentrate on looking for new work. Other medical conditions include hypothyroidism and migraine headaches. The patient drinks 1 or 2 glasses of wine a few times a week and smokes marijuana once a month. Medications include levothyroxine and naproxen. Physical examination is normal. TSH level is 0.9 μU/mL. Which of the following is the most likely diagnosis in this patient?

- A. Adjustment disorder with depressed mood
- B. Bipolar II disorder
- C. Depressive disorder due to another medical condition
- D. Major depressive disorder
- E. Persistent depressive disorder
- F. Premenstrual dysphoric disorder
- G. Substance-induced depressive disorder

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- A. Adjustment disorder with depressed mood (36%)
- B. Bipolar II disorder (0%)
- C. Depressive disorder due to another medical condition (10%)
- ✓ D. Major depressive disorder (44%)
- E. Persistent depressive disorder (2%)
- F. Premenstrual dysphoric disorder (2%)
- G. Substance-induced depressive disorder (2%)

Omitted
Correct answer
D

44%
Answered correctly

01 sec
Time Spent

02/17/2020
Last Updated

Explanation

Major depressive disorder

Major depressive disorder	
Diagnosis	• ≥5 of the following symptoms lasting ≥2 weeks (at least 1 symptom must be either depressed mood or loss of interest/pleasure): ◦ Depressed mood ◦ Loss of interest or pleasure ◦ Change in appetite or weight ◦ Insomnia or hypersomnia ◦ Psychomotor retardation or agitation ◦ Low energy ◦ Poor concentration or indecisiveness ◦ Thoughts of worthlessness or inappropriate guilt ◦ Recurrent thoughts of death or suicide • No history of mania or hypomania • Not due to substances or another medical condition
Treatment	• Psychotherapy • Antidepressant medication

This patient's symptoms (eg, depressed mood, feelings of worthlessness, low energy, insomnia, weight loss, and poor concentration) lasting **≥2 weeks** meets the criteria for **major depressive disorder** (MDD). The presence of MDD criterion symptoms for ≥2 weeks is all that is required for diagnosis, but the median duration of an MDD episode is approximately 6 months. Accurate diagnosis of MDD requires ruling out medical and substance-induced causes. Despite a history of hypothyroidism in this patient, her normal TSH level indicates that her hypothyroidism is adequately controlled with levothyroxine and would not be considered a medical cause of her depression **(Choice C)**.

Patients with sufficient depressive symptoms are diagnosed with MDD even if there is a clear psychosocial stressor that precipitated the depression (ie, this patient meets the criteria for MDD and therefore cannot be diagnosed with an adjustment disorder) **(Choice A)**. In patients who do not meet the criteria for MDD, adjustment disorder with depressed mood may be diagnosed if sadness, distress, and functional impairment develop ≤3 months following a psychosocial stressor.

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	• Antidepressant medication

This patient's symptoms (eg, depressed mood, feelings of worthlessness, low energy, insomnia, weight loss, and poor concentration) lasting **≥2 weeks** meets the criteria for **major depressive disorder** (MDD). The presence of MDD criterion symptoms for ≥2 weeks is all that is required for diagnosis, but the median duration of an MDD episode is approximately 6 months. Accurate diagnosis of MDD requires ruling out medical and substance-induced causes. Despite a history of hypothyroidism in this patient, her normal TSH level indicates that her hypothyroidism is adequately controlled with levothyroxine and would not be considered a medical cause of her depression **(Choice C)**.

Patients with sufficient depressive symptoms are diagnosed with MDD even if there is a clear psychosocial stressor that precipitated the depression (ie, this patient meets the criteria for MDD and therefore cannot be diagnosed with an adjustment disorder) **(Choice A)**. In patients who do not meet the criteria for MDD, adjustment disorder with depressed mood may be diagnosed if sadness, distress, and functional impairment develop ≤3 months following a psychosocial stressor.

(Choice B) This patient has no known history of hypomanic episodes required for a diagnosis of bipolar II disorder.

(Choice E) Persistent depressive disorder is diagnosed when depressive symptoms have lasted ≥2 years. It includes both pure dysthymia and chronic major depression.

(Choice F) Some women with mood disorders report that their symptoms worsen before their menstrual periods. However, in premenstrual dysphoric disorder, depressive symptoms must remit with the onset of menses and the diagnosis must be confirmed by daily prospective ratings over several cycles.

(Choice G) In substance-induced depressive disorder, a substance (eg, drug of abuse, medication, toxin) is judged to be etiologically related to the mood disturbance. The extent of this patient's substance use makes it an unlikely cause of her depressive disorder.

Educational objective:
Patients with sufficient depressive symptoms are diagnosed with major depressive disorder even if there is a clear psychosocial stressor that precipitated the depression.

References

- Major depressive disorder in DSM-5: implications for clinical practice and research of changes from DSM-IV.

This patient's symptoms (eg, depressed mood, feelings of worthlessness, low energy, insomnia, weight loss, and poor concentration) lasting **≥2 weeks** meets the criteria for **major depressive disorder** (MDD). The presence of MDD criterion symptoms for ≥2 weeks is all that is required for diagnosis, but the median duration of an MDD episode is approximately 6 months. Accurate diagnosis of MDD requires ruling out medical and substance-induced causes. Despite a history of hypothyroidism in this patient, her normal TSH level indicates that her hypothyroidism is adequately controlled with levothyroxine and would not be considered a medical cause of her depression **(Choice C)**.

Patients with sufficient depressive symptoms are diagnosed with MDD even if there is a clear psychosocial stressor that precipitated the depression (ie, this patient meets the criteria for MDD and therefore cannot be diagnosed with an adjustment disorder) **(Choice A)**. In patients who do not meet the criteria for MDD, adjustment disorder with depressed mood may be diagnosed if sadness, distress, and functional impairment develop ≤3 months following a psychosocial stressor.

(Choice B) This patient has no known history of hypomanic episodes required for a diagnosis of bipolar II disorder.

(Choice E) Persistent depressive disorder is diagnosed when depressive symptoms have lasted ≥2 years. It includes both pure dysthymia and chronic major depression.

(Choice F) Some women with mood disorders report that their symptoms worsen before their menstrual periods. However, in premenstrual dysphoric disorder, depressive symptoms must remit with the onset of menses and the diagnosis must be confirmed by daily prospective ratings over several cycles.

(Choice G) In substance-induced depressive disorder, a substance (eg, drug of abuse, medication, toxin) is judged to be etiologically related to the mood disturbance. The extent of this patient's substance use makes it an unlikely cause of her depressive disorder.

Educational objective:
Patients with sufficient depressive symptoms are diagnosed with major depressive disorder even if there is a clear psychosocial stressor that precipitated the depression.

References

- Major depressive disorder in DSM-5: implications for clinical practice and research of changes from DSM-IV.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Depression
Subject	System	Topic

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A 31-year-old woman comes to the office for a yearly checkup. The patient has no medical conditions but expresses dissatisfaction with her appearance and wishes she could lose weight more easily. She reports occasional constipation and fatigue. The patient exercises daily and drinks 1 or 2 glasses of wine 2-3 times a week when socializing with friends. Weight is 58.1 kg (128 lb) and height is 157.5 cm (5 ft 2 in). BMI is 23.4 kg/m^2. Routine laboratory evaluation shows a potassium level of 3.1 mEq/L. Physical examination is most likely to show which of the following abnormalities?

A. Bradycardia
B. Diaphoresis
C. Goiter
D. Hypertension
E. Lanugo
F. Malar rash
G. Parotid gland enlargement

Submit

A 31-year-old woman comes to the office for a yearly checkup. The patient has no medical conditions but expresses dissatisfaction with her appearance and wishes she could lose weight more easily. She reports occasional constipation and fatigue. The patient exercises daily and drinks 1 or 2 glasses of wine 2-3 times a week when socializing with friends. Weight is 58.1 kg (128 lb) and height is 157.5 cm (5 ft 2 in). BMI is 23.4 kg/m^2. Routine laboratory evaluation shows a potassium level of 3.1 mEq/L. Physical examination is most likely to show which of the following abnormalities?

- A. Bradycardia (17%)
- B. Diaphoresis (1%)
- C. Goiter (8%)
- D. Hypertension (6%)
- E. Lanugo (4%)
- F. Malar rash (0%)
- ✓ G. Parotid gland enlargement (61%)

Omitted
Correct answer
G

61%
Answered correctly

01 sec
Time Spent

02/18/2020
Last Updated

Explanation

Bulimia nervosa	

Bulimia nervosa	
Clinical features	• Recurrent episodes of binge eating & inappropriate compensatory behavior (eg, vomiting, laxatives, excessive exercise) • Excessive preoccupation with body weight & shape • Body weight within or above normal range • Symptoms: abdominal pain, bloating, constipation, lethargy, irregular menses
Physical examination	• Hypotension, tachycardia • Dental enamel erosion, caries • Dorsal hand calluses • Parotid gland swelling
Laboratory findings	• Hypokalemia • Metabolic alkalosis

Hypokalemia in an otherwise healthy young adult with a normal BMI and preoccupation with body shape and weight is concerning for **self-induced vomiting** associated with **bulimia nervosa** (BN). BN is characterized by repeated episodes of binge eating followed by **compensatory behaviors** (eg, vomiting, laxative use, fasting, excessive exercise) to prevent weight gain. Because patients may not be forthcoming about their eating behavior due to embarrassment, physical examination and laboratory assessment can assist in making the diagnosis. Painless bilateral **parotid gland enlargement** due to repetitive vomiting is a common finding.

Other signs of BN include tachycardia, hypotension, dry skin, calluses or scarring on the dorsum of the hand (Russell sign), and erosion of dental enamel. Common electrolyte abnormalities in BN include hypokalemia and metabolic alkalosis.

(Choices A, B, and D) BN is more commonly associated with tachycardia, dry skin, and hypotension rather than bradycardia (typically seen in anorexia nervosa), diaphoresis, and hypertension.

(Choice C) Goiter can be asymptomatic or associated with symptoms of hypothyroidism or hyperthyroidism. Hypothyroidism can present with fatigue and constipation but would not explain this patient's hypokalemia.

(Choice E) Lanugo hair growth (soft, downy hair typical of newborns) more commonly occurs in anorexia nervosa due to malnutrition.

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(Choice E) Lanugo hair growth (soft, downy hair typical of newborns) more commonly occurs in anorexia nervosa due to malnutrition.

(Choice F) A malar (butterfly) rash is a characteristic finding in systemic lupus erythematosus, a condition often associated with fatigue. However, other typical findings, including fever, weight loss, and myalgias, are not present in this patient.

Educational objective:
Hypokalemia in an otherwise healthy young adult with a normal BMI and preoccupation with body size is concerning for self-induced vomiting associated with bulimia nervosa. Common physical examination findings in bulimia nervosa include tachycardia, hypotension, painless bilateral parotid gland swelling, calluses or scarring on the dorsum of the hand, and erosion of dental enamel.

References

- Bulimia nervosa - medical complications.
- Medical complications of anorexia nervosa and bulimia.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Bulimia nervosa
Subject	System	Topic

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A 26-year-old woman comes to the office due to recent weight gain. She has eaten more than usual over the last 5 months, has gained 3.2 kg (7 lb), and feels guilty and depressed about it. Further questioning reveals that she consumes a large pizza and two large bags of chips in one sitting several times a week. Afterward, the patient feels ashamed about being unable to control her intake and fasts to make up for it. She is very distressed about being unable to lose weight despite exercising 2-3 hours a day. Vital signs are within normal limits. BMI is 23.7 kg/m^2. Despite being told that her BMI is normal, the patient insists that she is overweight. Which of the following is the most likely diagnosis?

A. Adjustment disorder with depressed mood

B. Anorexia nervosa

C. Binge-eating disorder

D. Body dysmorphic disorder

E. Bulimia nervosa

F. Normal behavior

Submit

A 26-year-old woman comes to the office due to recent weight gain. She has eaten more than usual over the last 5 months, has gained 3.2 kg (7 lb), and feels guilty and depressed about it. Further questioning reveals that she consumes a large pizza and two large bags of chips in one sitting several times a week. Afterward, the patient feels ashamed about being unable to control her intake and fasts to make up for it. She is very distressed about being unable to lose weight despite exercising 2-3 hours a day. Vital signs are within normal limits. BMI is 23.7 kg/m^2. Despite being told that her BMI is normal, the patient insists that she is overweight. Which of the following is the most likely diagnosis?

- A. Adjustment disorder with depressed mood (0%)
- B. Anorexia nervosa (2%)
- C. Binge-eating disorder (34%)
- D. Body dysmorphic disorder (9%)
- ✓ E. Bulimia nervosa (53%)
- F. Normal behavior (0%)

Omitted
Correct answer
E

53%
Answered correctly

01 sec
Time Spent

02/01/2020
Last Updated

Explanation

Eating disorders		
Diagnosis	Clinical features	Treatment

Eating disorders		
Diagnosis	**Clinical features**	**Treatment**
Anorexia nervosa	• **BMI <18.5 kg/m^2** • Intense fear of weight gain • Distorted views of body weight & shape	• Cognitive-behavioral therapy • Nutritional rehabilitation • **Olanzapine** if no response to first-line treatments
Bulimia nervosa	• Recurrent episodes of binge eating • Binge eating and **inappropriate compensatory behavior** to prevent weight gain • Excessive worrying about body shape & weight	• Cognitive-behavioral therapy • Nutritional rehabilitation • **SSRI (fluoxetine)**, often in combination with first-line treatments
Binge-eating disorder	• Recurrent episodes of binge eating • **No inappropriate compensatory behaviors** • Lack of control during eating	• Cognitive-behavioral therapy • Behavioral weight loss therapy • SSRI • Lisdexamfetamine, topiramate

SSRI = selective serotonin reuptake inhibitor.

This patient's recurrent episodes of **eating large amounts** of food and sense of loss of control, together with compensatory behaviors (fasting, exercising) to prevent weight gain, is consistent with **bulimia nervosa** (BN). Patients with BN are excessively preoccupied with their weight and body shape. Although self-induced vomiting is the most common **compensatory behavior**, patients may also fast and exercise excessively or misuse laxatives, enemas, diuretics, or diet pills. In DSM-5, both binges and inappropriate compensatory behaviors must occur at least once a week for 3 months for diagnosis. Patients with BN are **normal weight or overweight**, in contrast to individuals with anorexia nervosa.

Signs of BN in patients who vomit regularly may include hypotension, tachycardia, dry skin, menstrual irregularities, erosion of dental enamel, parotid hypertrophy, calloused knuckles, and electrolyte abnormalities (eg, hypokalemia, hypochloremia, metabolic alkalosis).

(Choice A) This patient's depressive and guilty feelings after a binge are characteristic of BN.

SSRI = selective serotonin reuptake inhibitor.

This patient's recurrent episodes of **eating large amounts** of food and sense of loss of control, together with compensatory behaviors (fasting, exercising) to prevent weight gain, is consistent with **bulimia nervosa** (BN). Patients with BN are excessively preoccupied with their weight and body shape. Although self-induced vomiting is the most common **compensatory behavior**, patients may also fast and exercise excessively or misuse laxatives, enemas, diuretics, or diet pills. In DSM-5, both binges and inappropriate compensatory behaviors must occur at least once a week for 3 months for diagnosis. Patients with BN are **normal weight or overweight**, in contrast to individuals with anorexia nervosa.

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(Choice A) This patient's depressive and guilty feelings after a binge are characteristic of BN.

(Choice B) Both BN and anorexia nervosa may be characterized by preoccupation with weight, binge eating, and compensatory behavior (there is a binge-eating/purging subtype of anorexia). Patients with anorexia nervosa have significantly low body weight (BMI <18.5 kg/m^2). In BN, body weight is typically normal to increased.

(Choice C) In binge-eating disorder, patients engage in recurrent episodes of binge eating but do not use inappropriate compensatory behaviors as in BN.

(Choice D) Body dysmorphic disorder is characterized by intense preoccupation with a perceived defect in physical appearance leading to significant functional impairment. It is not diagnosed when weight gain is the preoccupation of an individual who meets the criteria for an eating disorder.

(Choice F) This patient's 5-month history of frequent binge-eating episodes, followed by fasting and exercising, meets criteria for BN.

Educational objective:
Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating followed by compensatory behaviors to prevent weight gain (eg, fasting, exercising, vomiting, using laxatives). In contrast to patients with anorexia nervosa, BN patients are normal weight to overweight.

References

- Eating disorders.

week for 3 months for diagnosis. Patients with BN are **normal weight or overweight**, in contrast to individuals with anorexia nervosa.

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Educational objective:
Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating followed by compensatory behaviors to prevent weight gain (eg, fasting, exercising, vomiting, using laxatives). In contrast to patients with anorexia nervosa, BN patients are normal weight to overweight.

References

- Eating disorders.
- Medical complications of bulimia nervosa.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Bulimia nervosa
Subject	System	Topic

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A 12-year-old girl is brought to the office for an annual checkup. The mother expresses concern about her daughter's behavior and poor grades, and says, "She is stubborn, irritable, overly emotional, and doesn't listen. She also seems resentful of her twin brother and deliberately annoys or upsets him. I can't get her to do chores or her homework, or go to bed on time." Over the past year, the mother has been called several times by the school guidance counselor about her daughter talking back to teachers and skipping classes. The patient says that school is "boring" and blames her behavior on "pointless rules and unreasonable demands," saying that her teachers are all "stupid." Which of the following is the most likely diagnosis in this patient?

A. Antisocial personality disorder
B. Attention-deficit hyperactivity disorder
C. Conduct disorder
D. Disruptive mood dysregulation disorder
E. Normal adolescent behavior
F. Oppositional defiant disorder

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- A. Antisocial personality disorder (1%)
- B. Attention-deficit hyperactivity disorder (3%)
- C. Conduct disorder (14%)
- D. Disruptive mood dysregulation disorder (3%)
- E. Normal adolescent behavior (14%)
- ✓ F. Oppositional defiant disorder (61%)

Omitted
Correct answer
F

61%
Answered correctly

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02/16/2020
Last Updated

Explanation

Clinical features of oppositional defiant disorder

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Clinical features of oppositional defiant disorder

Pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness for ≥6 months

- Argues with adults, defies authority figures, refuses to follow rules
- Deliberately annoys others
- Blames others for own mistakes or misbehavior
- Easily annoyed, angered, resentful, or vindictive
- Not due to another mental disorder

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This patient's pattern of deliberately annoying behavior and defiance of rules and authority figures that causes problems at home and at school suggests a diagnosis of **oppositional defiant disorder** (ODD). Blaming failures on others and being **angry**, **argumentative** or resentful are also characteristic of the disorder. Although the behavior often manifests with family members, it must also be observed during interactions with other individuals.

For diagnosis, the oppositional behaviors must be excessive in frequency and duration when compared to normative age-appropriate behaviors. Although adolescents may test boundaries and assert their independence, this patient's 1-year history of persistent **defiance**, skipping classes, repeated refusal to follow rules, and **irritable** mood are beyond what would be expected for a 12-year-old girl **(Choice E)**.

(Choice A) Antisocial personality disorder is characterized by a pattern of disregard for and violation of the rights of others and is not diagnosed in individuals age <18.

(Choice B) Although attention-deficit hyperactivity disorder (ADHD) is commonly comorbid with ODD, this patient does not exhibit characteristic inattentive and hyperactive symptoms. Children with ODD should be assessed and treated for comorbid ADHD and learning disorders.

(Choice C) ODD should be differentiated from conduct disorder, in which the problematic behaviors are more severe and aggressive. This patient does not exhibit destruction of property, physical aggression or cruelty toward people or animals, or the typical pattern of stealing or deceit seen in conduct disorder.

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(Choice A) Antisocial personality disorder is characterized by a pattern of disregard for and violation of the rights of others and is not diagnosed in individuals age <18.

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(Choice C) ODD should be differentiated from conduct disorder, in which the problematic behaviors are more severe and aggressive. This patient does not exhibit destruction of property, physical aggression or cruelty toward people or animals, or the typical pattern of stealing or deceit seen in conduct disorder.

(Choice D) In disruptive mood dysregulation disorder, patients also present with irritable mood. However, this is accompanied by repetitive temper outbursts (verbal or physical) that are out of proportion to the stimulus and inconsistent with developmental level. Symptoms should manifest prior to age 10.

Educational objective:
Oppositional defiant disorder is a behavioral disorder of childhood characterized by argumentative and defiant behavior toward authority figures. It does not involve the more severe violations of the basic rights of others seen in conduct disorder.

References

- Oppositional defiant disorder.
- Common questions about oppositional defiant disorder.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Oppositional defiant disorder
Subject	System	Topic

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A 22-year-old college student comes to the office due to tension headaches and neck pain. He has had these symptoms for many years, but they have increased in frequency over the past 7 months since he started working at a coffee shop. The patient attends college and says that although his grades are passing, he feels overwhelmed and fatigued: "I can't concentrate on my schoolwork and worry that I will flunk out of school and never get a good job." He sleeps very fitfully and frequently worries about his grades, health, and social life. He obsesses about minor comments his friends have made about how "serious" he is, and gets depressed thinking that he is not attractive enough to get a girlfriend. Which of the following is the most likely diagnosis in this patient?

A. Adjustment disorder
B. Generalized anxiety disorder
C. Major depressive disorder
D. Obsessive-compulsive personality disorder
E. Social anxiety disorder
F. Somatic symptom disorder

Submit

A 22-year-old college student comes to the office due to tension headaches and neck pain. He has had these symptoms for many years, but they have increased in frequency over the past 7 months since he started working at a coffee shop. The patient attends college and says that although his grades are passing, he feels overwhelmed and fatigued: "I can't concentrate on my schoolwork and worry that I will flunk out of school and never get a good job." He sleeps very fitfully and frequently worries about his grades, health, and social life. He obsesses about minor comments his friends have made about how "serious" he is, and gets depressed thinking that he is not attractive enough to get a girlfriend. Which of the following is the most likely diagnosis in this patient?

- A. Adjustment disorder (2%)
- ✓ B. Generalized anxiety disorder (77%)
- C. Major depressive disorder (4%)
- D. Obsessive-compulsive personality disorder (4%)
- E. Social anxiety disorder (5%)
- F. Somatic symptom disorder (5%)

Omitted
Correct answer
B

77%
Answered correctly

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Time Spent

02/08/2020
Last Updated

Explanation

Generalized anxiety disorder	
	• Excessive, uncontrollable worry (multiple issues) ≥6 months

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Generalized anxiety disorder	

Clinical features	• Excessive, uncontrollable worry (multiple issues) ≥6 months
	• ≥3 of the following symptoms:
	  ◦ Restlessness; feeling on edge
	  ◦ Fatigue
	  ◦ Difficulty concentrating
	  ◦ Irritability
	  ◦ Muscle tension
	  ◦ Sleep disturbance

Treatment	• Cognitive-behavioral therapy • SSRIs or SNRIs

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

This patient's excessive chronic anxiety, muscle tension (tension headaches, neck pain), sleep disturbance, fatigue, and difficulty concentrating all support a diagnosis of **generalized anxiety disorder (GAD)**. Patients with GAD experience excessive and **uncontrollable worry** about **multiple issues**. A symptom duration of ≥6 months is required for diagnosis, but many patients with GAD describe lifelong anxiety. In addition to muscle tension, other somatic symptoms are commonly seen (eg, sweating, gastrointestinal distress) and may prompt the patient to seek medical attention. First-line treatment includes cognitive-behavioral therapy and antidepressants (ie, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors).

(Choice A) In adjustment disorder, behavioral symptoms develop within 3 months of an identifiable stressor and do not meet criteria for any other DSM-5 disorder. This patient's symptoms are not the result of a specific inciting factor.

(Choice C) Although some symptoms of GAD overlap with depression (ie, sleep disturbance, low energy, poor concentration), this patient is predominantly anxious. His depression is related to his worries about social acceptance; he does not meet the full criteria for a major depressive disorder.

SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor.

This patient's excessive chronic anxiety, muscle tension (tension headaches, neck pain), sleep disturbance, fatigue, and difficulty concentrating all support a diagnosis of **generalized anxiety disorder (GAD)**. Patients with GAD experience excessive and **uncontrollable worry** about **multiple issues**. A symptom duration of ≥6 months is required for diagnosis, but many patients with GAD describe lifelong anxiety. In addition to muscle tension, other somatic symptoms are commonly seen (eg, sweating, gastrointestinal distress) and may prompt the patient to seek medical attention. First-line treatment includes cognitive-behavioral therapy and antidepressants (ie, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors).

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(Choice C) Although some symptoms of GAD overlap with depression (ie, sleep disturbance, low energy, poor concentration), this patient is predominantly anxious. His depression is related to his worries about social acceptance; he does not meet the full criteria for a major depressive disorder.

(Choice D) Obsessive-compulsive personality disorder is characterized by a need for perfectionism, control, and orderliness.

(Choice E) In social anxiety disorder, anxiety occurs exclusively in response to social interactions in which the patient fears negative evaluation by others. In contrast, this patient's concerns extend to multiple situations.

(Choice F) Patients with GAD frequently have anxiety about their health but among a range of other concerns. In somatic symptom disorder, the distress is centered on ≥1 somatic symptoms.

Educational objective:
Generalized anxiety disorder involves excessive uncontrollable worry about multiple issues with a symptom duration of ≥6 months. Associated symptoms include restlessness, muscle tension, fatigue, sleep disturbance, irritability, and difficulty concentrating.

References

- Diagnosis and management of generalized anxiety disorder and panic disorder in adults.
- Generalized anxiety disorder, subthreshold anxiety and anxiety symptoms in primary headache.

tension, other somatic symptoms are commonly seen (eg, sweating, gastrointestinal distress) and may prompt the patient to seek medical attention. First-line treatment includes cognitive-behavioral therapy and antidepressants (ie, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors).

(Choice A) In adjustment disorder, behavioral symptoms develop within 3 months of an identifiable stressor and do not meet criteria for any other DSM-5 disorder. This patient's symptoms are not the result of a specific inciting factor.

(Choice C) Although some symptoms of GAD overlap with depression (ie, sleep disturbance, low energy, poor concentration), this patient is predominantly anxious. His depression is related to his worries about social acceptance; he does not meet the full criteria for a major depressive disorder.

(Choice D) Obsessive-compulsive personality disorder is characterized by a need for perfectionism, control, and orderliness.

(Choice E) In social anxiety disorder, anxiety occurs exclusively in response to social interactions in which the patient fears negative evaluation by others. In contrast, this patient's concerns extend to multiple situations.

(Choice F) Patients with GAD frequently have anxiety about their health but among a range of other concerns. In somatic symptom disorder, the distress is centered on ≥1 somatic symptoms.

Educational objective:
Generalized anxiety disorder involves excessive uncontrollable worry about multiple issues with a symptom duration of ≥6 months. Associated symptoms include restlessness, muscle tension, fatigue, sleep disturbance, irritability, and difficulty concentrating.

References

- Diagnosis and management of generalized anxiety disorder and panic disorder in adults.
- Generalized anxiety disorder, subthreshold anxiety and anxiety symptoms in primary headache.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Generalized anxiety disorder
Subject	System	Topic

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A 54-year-old man arrives for an appointment with a new physician. At the front desk, the receptionist tells him that the physician is running behind schedule and gives him several forms to complete regarding his personal and family medical history. The patient politely agrees to fill them out and has a seat in the waiting area. However, when his paperwork is reviewed by the physician, it contains only the patient's signature. The patient says, "I'm sure a doctor with your education can take a good history." When asked if anything is wrong he says, "Oh, nothing, I'm fine." Which of the following best describes this patient's behavior?

A. Acting out
B. Displacement
C. Passive aggression
D. Reaction formation
E. Splitting
F. Suppression
G. Undoing

Submit

A 54-year-old man arrives for an appointment with a new physician. At the front desk, the receptionist tells him that the physician is running behind schedule and gives him several forms to complete regarding his personal and family medical history. The patient politely agrees to fill them out and has a seat in the waiting area. However, when his paperwork is reviewed by the physician, it contains only the patient's signature. The patient says, "I'm sure a doctor with your education can take a good history." When asked if anything is wrong he says, "Oh, nothing, I'm fine." Which of the following best describes this patient's behavior?

- A. Acting out (2%)
- B. Displacement (0%)
- ✓ C. Passive aggression (88%)
- D. Reaction formation (3%)
- E. Splitting (1%)
- F. Suppression (1%)
- G. Undoing (1%)

Omitted
Correct answer
C

88%
Answered correctly

01 sec
Time Spent

06/22/2020
Last Updated

Explanation

Key defense mechanisms	

Key defense mechanisms	
Immature	• Acting out: Expressing unacceptable feelings through actions • Denial: Behaving as if an aspect of reality does not exist • Displacement: Transferring feelings to less threatening object/person • Intellectualization: Focusing on nonemotional aspects to avoid distressing feelings • Passive aggression: Avoiding conflict by expressing hostility covertly • Projection: Attributing one's own feelings to others • Rationalization: Justifying behavior to avoid difficult truths • Reaction formation: Transforming unacceptable feelings/impulses into the opposite • Regression: Reverting to earlier developmental stage • Splitting: Experiencing a person/situation as either all positive or all negative
Mature	• Sublimation: Channeling impulses into socially acceptable behaviors • Suppression: Putting unwanted feelings aside to cope with reality

This patient's **indirect expression of anger** about having to wait for the physician is an example of **passive aggression**. Rather than directly expressing his feelings, he agrees to fill out the forms and then resists performing the expected task. Other examples of behaviors used to indirectly defuse hostile feelings include procrastination, forgetfulness, and purposeful inefficiency. Backhanded compliments, sarcasm, and denial of being angry are also characteristic of passive-aggressive behavior.

(Choice A) Acting out is an immature defense mechanism that involves expressing unconscious wishes or impulses through overtly aggressive actions (eg, the patient tore up the forms in anger).

(Choice B) In displacement, negative feelings associated with a person or situation are transferred to another person or object that appears less threatening (eg, the patient did not express his anger to the physician but yelled at his wife instead).

(Choice D) In reaction formation, unacceptable feelings are transformed into their opposites (eg, the patient's irritation was redirected into being overly complimentary to the physician).

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(Choice D) In reaction formation, unacceptable feelings are transformed into their opposites (eg, the patient's irritation was redirected into being overly complimentary to the physician).

(Choice E) Splitting involves experiencing the self or others in extremes, either all positive or all negative (eg, the patient was told of the delay in his appointment time and then perceived the physician as horrible with no redeeming qualities).

(Choice F) Suppression involves consciously putting aside unwanted feelings (eg, the patient made a conscious decision to temporarily put aside his anger, completed the paperwork as directed, and was cordial to the physician during the appointment).

(Choice G) Undoing involves symbolically nullifying a guilt-provoking thought or feeling by confession or atonement (eg, this patient brought the physician a gift at his next appointment to negate his angry feelings). Undoing is commonly seen in obsessive-compulsive disorder.

Educational objective:
Passive aggression is the expression of angry feelings in a nonconfrontational manner.

References

- Understanding defense mechanisms.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Defense mechanisms
Subject	System	Topic

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A 23-year-old man comes to the physician at his girlfriend's insistence. She says that the patient's frequent snoring keeps her up at night and that in the last 4 months he has twice fallen asleep while they were talking. In this same period, the patient says that he has regularly fallen asleep in the afternoon while reading or watching television but typically feels refreshed after a brief nap. When asked whether he experiences any other symptoms, the patient hesitantly reveals that he sometimes hears a voice call his name prior to falling asleep. He also reports uncharacteristic episodes of clumsiness in which he has suddenly dropped objects or fallen to his knees. Examination shows no abnormalities. Which of the following is the most likely diagnosis in this patient?

A. Brief psychotic disorder
B. Delayed sleep-wake phase disorder
C. Idiopathic hypersomnia
D. Insufficient sleep
E. Narcolepsy
F. Obstructive sleep apnea
G. REM sleep behavior disorder

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- A. Brief psychotic disorder (0%)
- B. Delayed sleep-wake phase disorder (1%)
- C. Idiopathic hypersomnia (1%)
- D. Insufficient sleep (1%)
- ✓ E. Narcolepsy (84%)
- F. Obstructive sleep apnea (7%)
- G. REM sleep behavior disorder (2%)

Omitted
Correct answer
E

84%
Answered correctly

02 secs
Time Spent

02/17/2020
Last Updated

Explanation

Narcolepsy

Narcolepsy	

DSM-5 diagnostic criteria	• Recurrent lapses into sleep or naps (≥3 times/week for 3 months)
	• ≥1 of the following:
	  ◦ Cataplexy: Brief loss of muscle tone precipitated by strong emotion (eg, laughter, excitement)
	  ◦ Low cerebrospinal fluid levels of hypocretin-1
	  ◦ Shortened REM sleep latency

Associated features	• Hypnagogic or hypnopompic hallucinations • Sleep paralysis

Narcolepsy is a chronic sleep disorder characterized by frequent, overwhelming urges to sleep. It is commonly associated with **cataplexy**, a sudden loss of muscle tone that occurs in response to intense (usually positive) emotions. Narcolepsy results from the depletion of hypocretin (also known as orexin)-secreting neurons in the lateral hypothalamus that are involved in maintaining wakefulness.

Patients with narcolepsy experience shortened sleep latency and typically enter rapid eye movement (REM) sleep almost immediately. They commonly experience intrusions of REM sleep phenomena during sleep-wake transitions, including **hypnagogic** (upon falling asleep) and **hypnopompic** (upon awakening) **hallucinations** and **sleep paralysis** (inability to move immediately after awakening). The clinical diagnosis of narcolepsy can be confirmed by **low cerebrospinal fluid** levels of **hypocretin-1** or shortened REM sleep latency on polysomnography.

(Choice A) This patient is experiencing hypnagogic hallucinations, which are characteristic of narcolepsy. Brief psychotic disorder is diagnosed when one or more positive psychotic symptoms are present for less than a month in the absence of another medical disorder or substance use.

(Choice B) Delayed sleep-wake phase disorder most often presents in adolescence and is characterized by intact duration and quality of sleep that is shifted to a later bedtime and wake time.

(Choice C) Idiopathic hypersomnia is diagnosed when excessive and impairing daytime sleepiness cannot be explained by another sleep disorder. Patients with idiopathic hypersomnia have persistent daytime sleepiness rather than "sleep attacks." Unlike patients with narcolepsy, they typically do not feel refreshed after naps.

(Choice D) Insufficient sleep may result in excessive daytime sleepiness, napping, and quicker REM onset, but it is not associated with cataplexy

when one or more positive psychotic symptoms are present for less than a month in the absence of another medical disorder or substance use.

(Choice B) Delayed sleep-wake phase disorder most often presents in adolescence and is characterized by intact duration and quality of sleep that is shifted to a later bedtime and wake time.

(Choice C) Idiopathic hypersomnia is diagnosed when excessive and impairing daytime sleepiness cannot be explained by another sleep disorder. Patients with idiopathic hypersomnia have persistent daytime sleepiness rather than "sleep attacks." Unlike patients with narcolepsy, they typically do not feel refreshed after naps.

(Choice D) Insufficient sleep may result in excessive daytime sleepiness, napping, and quicker REM onset, but it is not associated with cataplexy or sleep-related hallucinations.

(Choice F) Obstructive sleep apnea, the most common cause of excessive daytime sleepiness, is characterized by loud snoring, gasping, and apneas during sleep. It is caused by upper airway obstruction and is not associated with cataplexy, sleep-related hallucinations, or sleep paralysis.

(Choice G) Patients with REM sleep behavior disorder lose normal sleep paralysis during REM sleep and, as a result, act out the content of their dreams (eg, punching, kicking).

Educational objective:
Narcolepsy is a chronic sleep disorder characterized by excessive daytime sleepiness, cataplexy, and REM sleep-related phenomena (ie, hypnagogic/hypnopompic hallucinations, sleep paralysis).

References

- Narcolepsy.
- Diagnosis and management of narcolepsy.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Narcolepsy
Subject	System	Topic

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A 32-year-old man comes to the office due to anxiety that has intensified since he was promoted to a managerial position. Whereas he previously worked alone, his new position requires him to interact with a team of five employees and handle customer service complaints. The patient says he is anxious throughout the day and fears that he will say something embarrassing or that his coworkers and customers will notice his anxiety and think he is incompetent. He says he was very quiet and shy growing up and would always get anxious when meeting new people. He has a few friends with whom he socializes, but he typically has three or four alcoholic drinks before going out with them to feel more relaxed. The patient does not feel depressed, and his sleep and appetite are normal. A medication with which of the following mechanisms of action would be most appropriate for this patient?

A. Beta adrenergic blockade

B. Dopamine and serotonin receptor antagonism

C. $GABA_A$ receptor agonism

D. Histamine receptor antagonism

E. Monoamine oxidase inhibition

F. Serotonin reuptake inhibition

Submit

A 32-year-old man comes to the office due to anxiety that has intensified since he was promoted to a managerial position. Whereas he previously worked alone, his new position requires him to interact with a team of five employees and handle customer service complaints. The patient says he is anxious throughout the day and fears that he will say something embarrassing or that his coworkers and customers will notice his anxiety and think he is incompetent. He says he was very quiet and shy growing up and would always get anxious when meeting new people. He has a few friends with whom he socializes, but he typically has three or four alcoholic drinks before going out with them to feel more relaxed. The patient does not feel depressed, and his sleep and appetite are normal. A medication with which of the following mechanisms of action would be most appropriate for this patient?

- A. Beta adrenergic blockade (13%)
- B. Dopamine and serotonin receptor antagonism (1%)
- C. $GABA_A$ receptor agonism (7%)
- D. Histamine receptor antagonism (0%)
- E. Monoamine oxidase inhibition (0%)
- ✓ F. Serotonin reuptake inhibition (75%)

Omitted
Correct answer
F

75%
Answered correctly

01 sec
Time Spent

01/23/2020
Last Updated

Explanation

Social anxiety disorder (social phobia)

Explanation

Social anxiety disorder (social phobia)	
Diagnosis	• Marked anxiety about ≥1 social situations for ≥6 months • Fear of scrutiny by others, humiliation, embarrassment • Social situations avoided or endured with intense distress • Marked impairment (social, academic, occupational) • Subtype specifier: performance only
Treatment	• SSRI/SNRI • Cognitive-behavioral therapy • Beta blocker or benzodiazepine for performance-only subtype

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

This patient's marked anxiety in social situations is consistent with **social anxiety disorder** (SAD). His fears of saying something embarrassing and negative evaluation by others are characteristic of the disorder. SAD is a common anxiety disorder with typical onset in childhood or adolescence. If untreated, the disorder can cause major impairment in social and occupational functioning and is often complicated by depression and self-medication with alcohol.

Drugs that inhibit the reuptake of serotonin are first-line medications for social anxiety disorder. Patients are commonly started on a **selective serotonin reuptake inhibitor** (SSRI) although there is also good evidence for the efficacy of **serotonin-norepinephrine reuptake inhibitors** (SNRIs). These medications work by blocking the serotonin transporter, causing an increase in the availability of serotonin in the synaptic cleft.

(Choice A) Beta blockers have been used to treat performance-only social anxiety disorder. They are taken on an as-needed basis and are most useful for patients with prominent physiological symptoms such as tachycardia or tremor. A beta blocker would not be appropriate for this patient who is generally socially anxious (ie, anxiety not limited to performance situations) and who experiences impairing anxiety on a daily basis.

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

This patient's marked anxiety in social situations is consistent with **social anxiety disorder** (SAD). His fears of saying something embarrassing and negative evaluation by others are characteristic of the disorder. SAD is a common anxiety disorder with typical onset in childhood or adolescence. If untreated, the disorder can cause major impairment in social and occupational functioning and is often complicated by depression and self-medication with alcohol.

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(Choice A) Beta blockers have been used to treat performance-only social anxiety disorder. They are taken on an as-needed basis and are most useful for patients with prominent physiological symptoms such as tachycardia or tremor. A beta blocker would not be appropriate for this patient who is generally socially anxious (ie, anxiety not limited to performance situations) and who experiences impairing anxiety on a daily basis.

(Choice B) Dopamine and serotonin receptor antagonism are the mechanisms of action of second-generation antipsychotics. These drugs are not indicated for SAD.

(Choice C) GABA A receptor agonism is the mechanism of action of benzodiazepines. Benzodiazepines are effective in SAD but are generally used as second-line agents due to their potential for tolerance, abuse, and dependence. They should be avoided in this patient who has a history of self-medication with alcohol.

(Choice D) Histamine receptor antagonism is the mechanism of action of antihistamines (eg, diphenhydramine). Although they have sedative effects, they are not effective in treating anxiety.

(Choice E) Monoamine oxidase inhibitors are effective for SAD but are not used as a first-line treatment due to their side effect profile and dietary restrictions.

Educational objective:
Social anxiety disorder is characterized by anxiety and fear of scrutiny in social situations and can result in marked social-occupational impairment. Preferred pharmacotherapy is medication that inhibits serotonin reuptake (eg, SSRIs or SNRIs).

(SNRIs). These medications work by blocking the serotonin transporter, causing an increase in the availability of serotonin in the synaptic cleft.

(Choice A) Beta blockers have been used to treat performance-only social anxiety disorder. They are taken on an as-needed basis and are most useful for patients with prominent physiological symptoms such as tachycardia or tremor. A beta blocker would not be appropriate for this patient who is generally socially anxious (ie, anxiety not limited to performance situations) and who experiences impairing anxiety on a daily basis.

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Educational objective:
Social anxiety disorder is characterized by anxiety and fear of scrutiny in social situations and can result in marked social-occupational impairment. Preferred pharmacotherapy is medication that inhibits serotonin reuptake (eg, SSRIs or SNRIs).

References

- The evidence-based pharmacotherapy of social anxiety disorder.
- Pharmacotherapy for social anxiety disorder (SAnD).

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Social anxiety disorder
Subject	System	Topic

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A 16-year-old girl is brought to the office by her mother due to nonspecific stomachaches and pains. She has no other medical history. The patient has missed more than 10 days of school due to the symptoms since the academic year started 6 months ago. The mother says that her daughter has always been anxious with a "sensitive stomach," but the symptoms have worsened since the patient's best friend moved away a month ago. She has a few other friends but prefers to stay home and does not participate in after-school activities. The mother says, "She worried for weeks about going to a party. On the night of the party she had an anxiety attack and started hyperventilating. She ended up not going to the party at all." The patient says she is "just very shy" and is afraid of being embarrassed or "looking stupid" around others. Physical examination shows no abnormalities. During the interview, the patient makes little eye contact and gives brief answers to questions. Which of the following is the most likely diagnosis?

- A. Adjustment disorder with anxiety
- B. Agoraphobia
- C. Generalized anxiety disorder
- D. Normal shyness
- E. Panic disorder
- F. Social anxiety disorder
- G. Somatic symptom disorder

Submit

A 16-year-old girl is brought to the office by her mother due to nonspecific stomachaches and pains. She has no other medical history. The patient has missed more than 10 days of school due to the symptoms since the academic year started 6 months ago. The mother says that her daughter has always been anxious with a "sensitive stomach," but the symptoms have worsened since the patient's best friend moved away a month ago. She has a few other friends but prefers to stay home and does not participate in after-school activities. The mother says, "She worried for weeks about going to a party. On the night of the party she had an anxiety attack and started hyperventilating. She ended up not going to the party at all." The patient says she is "just very shy" and is afraid of being embarrassed or "looking stupid" around others. Physical examination shows no abnormalities. During the interview, the patient makes little eye contact and gives brief answers to questions. Which of the following is the most likely diagnosis?

- A. Adjustment disorder with anxiety (7%)
- B. Agoraphobia (2%)
- C. Generalized anxiety disorder (4%)
- D. Normal shyness (1%)
- E. Panic disorder (1%)
- ✓ F. Social anxiety disorder (77%)
- G. Somatic symptom disorder (3%)

Omitted
Correct answer
F

77%
Answered correctly

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Time Spent

01/25/2020
Last Updated

Explanation

Explanation

Social anxiety disorder (social phobia)	
Diagnosis	• Marked anxiety about ≥1 social situations for ≥6 months • Fear of scrutiny by others, humiliation, embarrassment • Social situations avoided or endured with intense distress • Marked impairment (social, academic, occupational) • Subtype specifier: performance only
Treatment	• SSRI/SNRI • Cognitive-behavioral therapy • Beta blocker or benzodiazepine for performance-only subtype

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

This patient's intense social anxiety, in which she **fears embarrassment** and **scrutiny** by others, is characteristic of **social anxiety disorder (social phobia)**. It is a common psychiatric disorder with typical **onset** in **adolescence** that can result in significant impairment in functioning and quality of life. Social interactions with peers and meeting new people cause significant distress. Anticipatory anxiety weeks before a social event and **avoidance** (not going to parties, school refusal) are common.

Patients with social anxiety disorder frequently appear ill at ease during the interview, avoid eye contact, give overly brief responses, and may exhibit physical manifestations of anxiety (eg, blushing, sweating, trembling, tachycardia). The specifier "performance-only" is given to patients who have symptoms only in performance situations (eg, speaking or performing in public).

(Choice A) This patient's social anxiety predates the stressor of her friend moving away. Stressors often exacerbate symptoms of other disorders. Adjustment disorder is not diagnosed when symptoms meet criteria for another disorder.

(Choice B) Individuals with agoraphobia avoid public situations (eg, movie theaters) as escape might be difficult or help might not be available if they are incapacitated or have panic like symptoms. Although individuals with social anxiety disorder may avoid leaving the house, this is primarily due to fear of embarrassment and scrutiny by others.

SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor.

This patient's intense social anxiety, in which she **fears embarrassment** and **scrutiny** by others, is characteristic of **social anxiety disorder (social phobia)**. It is a common psychiatric disorder with typical **onset** in **adolescence** that can result in significant impairment in functioning and quality of life. Social interactions with peers and meeting new people cause significant distress. Anticipatory anxiety weeks before a social event and **avoidance** (not going to parties, school refusal) are common.

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(Choice C) This patient's anxiety is restricted to social situations, whereas generalized anxiety is characterized by multiple worries.

(Choice D) Shyness is a common nonpathological personality trait. However, this patient's severe and pervasive anxiety is out of proportion to the actual threat posed by social situations. It is causing significant distress and functional impairment in both academic and social contexts.

(Choice E) Patients with social anxiety disorder may have panic attacks related to social situations. In panic disorder, however, attacks are unexpected and there is no clear trigger.

(Choice G) Patients with anxiety disorders often present with somatic symptoms. This patient's stomachaches are a physical manifestation of her anxiety. She does not exhibit the excessive preoccupation with physical symptoms that characterizes somatic symptom disorder.

Educational objective:
Social anxiety disorder involves excessive fear of scrutiny or embarrassment in social or performance situations, resulting in significant distress and functional impairment.

References

(Choice A) This patient's social anxiety predates the stressor of her friend moving away. Stressors often exacerbate symptoms of other disorders. Adjustment disorder is not diagnosed when symptoms meet criteria for another disorder.

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Educational objective:
Social anxiety disorder involves excessive fear of scrutiny or embarrassment in social or performance situations, resulting in significant distress and functional impairment.

References

- Social anxiety disorder in adolescence: how developmental cognitive neuroscience findings may shape understanding and interventions for psychopathology.
- Social anxiety disorder in DSM-5.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Social anxiety disorder
Subject	System	Topic

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A 32-year-old woman comes to the office due to overwhelming anxiety and stress. The patient is an accountant and has been under increasing job-related pressure for the past 6 weeks due to an upcoming tax deadline. She says, "The worst part is that I get really nervous all of a sudden and then feel shaky, dizzy, and nauseated and start to sweat. It happened while I spoke to my boss a few weeks ago, and I had to excuse myself." The patient is especially worried about having an episode during a work meeting, although she notes that her symptoms have also occurred while she was relaxing at home. She says, "I've stopped going out with my friends because I never know when I'm going to feel this way." The patient has no significant medical history and does not use alcohol or drugs. Blood pressure is 120/70 mm Hg, pulse is 72/min, and respirations are 18/min. Physical examination and laboratory evaluation show no abnormalities. Which of the following is the most likely diagnosis?

- A. Acute stress disorder
- B. Adjustment disorder with anxious mood
- C. Generalized anxiety disorder
- D. Panic disorder
- E. Social anxiety disorder
- F. Specific phobia

Submit

A 32-year-old woman comes to the office due to overwhelming anxiety and stress. The patient is an accountant and has been under increasing job-related pressure for the past 6 weeks due to an upcoming tax deadline. She says, "The worst part is that I get really nervous all of a sudden and then feel shaky, dizzy, and nauseated and start to sweat. It happened while I spoke to my boss a few weeks ago, and I had to excuse myself." The patient is especially worried about having an episode during a work meeting, although she notes that her symptoms have also occurred while she was relaxing at home. She says, "I've stopped going out with my friends because I never know when I'm going to feel this way." The patient has no significant medical history and does not use alcohol or drugs. Blood pressure is 120/70 mm Hg, pulse is 72/min, and respirations are 18/min. Physical examination and laboratory evaluation show no abnormalities. Which of the following is the most likely diagnosis?

- A. Acute stress disorder (9%)
- B. Adjustment disorder with anxious mood (3%)
- C. Generalized anxiety disorder (10%)
- ✓ D. Panic disorder (74%)
- E. Social anxiety disorder (2%)
- F. Specific phobia (0%)

Omitted
Correct answer
D

74%
Answered correctly

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Time Spent

06/06/2020
Last Updated

Explanation

Differential diagnosis of DSM-5 anxiety disorders	
Social anxiety disorder (social phobia)	Anxiety restricted to social & performance situations, **fear of scrutiny** & embarrassment
Panic disorder	Recurrent, **unexpected** panic attacks
Specific phobia	Excessive anxiety about a **specific object** or situation (phobic stimulus)
Generalized anxiety disorder	**Chronic multiple worries**, anxiety, tension

This patient's repeated episodes of acute-onset anxiety accompanied by physical symptoms (shaking, dizziness, nausea, sweating) are characteristic of panic disorder. Diagnosis requires **recurrent**, **unexpected panic attacks**, typically reaching a peak within minutes and followed by persistent **concern** about **additional attacks** and/or changes in behavior (eg, patient may restrict activities due to fear of an attack). Characteristic physical symptoms include chest pain, shortness of breath, tachycardia, and gastrointestinal and neurological symptoms. A key feature is that at least some of the attacks are spontaneous with no obvious trigger (eg, when an individual is relaxing or emerging from sleep [ie, nocturnal panic attack]).

Diagnosis of panic disorder requires first ruling out medical and substance-related causes (eg, hyperthyroidism, alcohol withdrawal). Physicians should also differentiate panic disorder from other anxiety and mental disorders with panic attacks as an associated feature. Panic-like symptoms that occur as part of other disorders are typically triggered by, and limited to, specific situations.

(Choice A) Acute stress disorder involves exposure to a traumatic event followed by development of characteristic symptoms (eg, re-experiencing, avoidance, arousal) lasting from 3 days to 1 month.

(Choice B) Although this patient experiences work-related stress, her description of unexpected panic attacks at home makes panic disorder more likely. Adjustment disorder requires that symptoms develop in response to an identifiable stressor and do not meet criteria for another mental disorder.

(Choice C) In generalized anxiety disorder, individuals experience chronic, excessive worry for at least 6 months about multiple issues (eg, work, health, finances), which may or may not precipitate panic attacks. In panic disorder, the content of anxious thoughts is more specific (concern

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(Choice C) In generalized anxiety disorder, individuals experience chronic, excessive worry for at least 6 months about multiple issues (eg, work, health, finances), which may or may not precipitate panic attacks. In panic disorder, the content of anxious thoughts is more specific (concern about having future panic attacks) and panic attacks are unexpected.

(Choice E) Patients with social anxiety disorder may experience panic attacks in response to social situations (identifiable stimulus) and fear negative evaluation by others rather than the panic symptoms themselves.

(Choice F) Specific phobia is characterized by fear of a specific object or situation, such as flying, heights, or animals. Panic symptoms are triggered by the phobic stimulus and are not spontaneous.

Educational objective:
Panic disorder involves recurrent, unexpected panic attacks characterized by an abrupt surge of fear accompanied by physical and cognitive symptoms. Individuals experience persistent worry about future attacks and typically restrict their activities as a result.

References

- Panic disorder and agoraphobia: an overview and commentary on DSM-5 changes.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Panic disorder
Subject	System	Topic

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Panic disorder	Recurrent, **unexpected** panic attacks
Speci	
Generalized	

This patient's repeated ep
characteristic of panic disc
by persistent **concern** abo
Characteristic physical sy
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Diagnosis of panic disorde
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negative evaluation by oth

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Exhibit Display

Panic disorder	
Clinical features	• Recurrent & unexpected panic attacks with ≥4 of the following: ◦ Chest pain, palpitations, shortness of breath, choking ◦ Trembling, sweating, nausea, chills ◦ Dizziness, paresthesias ◦ Derealization, depersonalization ◦ Fear of losing control or of dying • Worry about additional attacks, avoidance behavior
Treatment	• First-line/maintenance: SSRI/SNRI &/or cognitive-behavioral therapy • Acute distress: benzodiazepines

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.

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A 14-year-old boy is brought to the office by his parents, who are worried about his reaction to their recent decision to divorce. Despite their efforts to be supportive and engage him, he has not expressed any feelings directly about the divorce. When the patient is evaluated alone, he shares that he feels his parents are angry with him, although he cannot think of any instances when they expressed any anger toward him. On examination, the patient appears sullen and reports his mood is "fine." This patient is most likely using which of the following defense mechanisms?

- A. Acting out
- B. Displacement
- C. Identification
- D. Projection
- E. Reaction formation
- F. Regression

Submit

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- A. Acting out (3%)
- B. Displacement (11%)
- C. Identification (6%)
- ✓ D. Projection (49%)
- E. Reaction formation (19%)
- F. Regression (9%)

Omitted
Correct answer
D

49%
Answered correctly

03 secs
Time Spent

07/06/2020
Last Updated

Explanation

Key defense mechanisms	
	• Acting out: Expressing unacceptable feelings through actions • Denial: Behaving as if an aspect of reality does not exist

Key defense mechanisms	
Immature	• Acting out: Expressing unacceptable feelings through actions • Denial: Behaving as if an aspect of reality does not exist • Displacement: Transferring feelings to less threatening object/person • Intellectualization: Focusing on nonemotional aspects to avoid distressing feelings • Passive aggression: Avoiding conflict by expressing hostility covertly • Projection: Attributing one's own feelings to others • Rationalization: Justifying behavior to avoid difficult truths • Reaction formation: Transforming unacceptable feelings/impulses into the opposite • Regression: Reverting to earlier developmental stage • Splitting: Experiencing a person/situation as either all positive or all negative
Mature	• Sublimation: Channeling impulses into socially acceptable behaviors • Suppression: Putting unwanted feelings aside to cope with reality

Projection is an immature defense mechanism that involves **misattributing** undesired **thoughts or feelings to another** person who does not actually have them to avoid acknowledgement in oneself. This patient is likely angry with his parents about the divorce, and, due to his inability to acknowledge these feelings, he projects them onto his parents. As a result, he perceives that his parents are angry with him, even though there is little evidence that they feel this way. Projection commonly occurs in patients who lack insight into their own motivations and feelings.

(Choice A) Acting out refers to expressing unwanted thoughts or impulses through actions (eg, if the boy expressed his anger by destroying his parents' wedding photographs).

(Choice B) Displacement involves redirecting unacceptable thoughts, feelings, and impulses intended for one person to a more neutral person or object (eg, if this patient redirected his anger at his parents toward a sibling).

(Choice C) Identification refers to modeling one's behavior after someone who is perceived to be more powerful or prestigious. A classic example is the child of an abusive father who becomes a child abuser himself.

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(Choice C) Identification refers to modeling one's behavior after someone who is perceived to be more powerful or prestigious. A classic example is the child of an abusive father who becomes a child abuser himself.

(Choice E) Reaction formation is the transformation of an unacceptable feeling to its opposite (eg, if instead of expressing anger, this patient behaved in an overly affectionate way toward his parents and enthusiastically supported their decision to divorce).

(Choice F) Regression refers to reverting to a less mature way of coping with difficulties (eg, if this patient began sleeping in his parents' room due to anxiety about being alone, which is more characteristic of an earlier developmental stage).

Educational objective:
Projection is an immature defense mechanism involving the misattribution of one's unacceptable feelings or thoughts to another person who does not actually have them.

References

- Understanding defense mechanisms.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Defense mechanisms
Subject	System	Topic

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A 45-year-old man comes to the office as a new patient. He is not doing well at his new job as an automobile salesman. After reading a book on adult attention-deficit hyperactivity disorder (ADHD), he believes that he has ADHD and requests treatment with stimulants. The patient has no history of childhood ADHD but claims that his parents were not aware of the disorder and never had him evaluated. He currently does not experience hyperactivity or impulsivity, but says, "I just get distracted easily and know I could be more productive." The patient's medical history is remarkable for hypertension, coronary artery disease, supraventricular tachycardia, and cocaine abuse. His blood pressure is 150/90 mm Hg and heart rate is 90/min. Physical examination is otherwise normal. The physician explains that the patient does not meet diagnostic criteria for ADHD and that his history of stimulant abuse and cardiac risks make him a poor candidate for stimulant therapy. After listening to the explanation, the patient insists that he will benefit from stimulants and understands their risks. Which of the following options is the best course of action?

- A. Do not prescribe stimulants as the patient is only being influenced by popular literature and pharmaceutical advertisements
- B. Do not prescribe stimulants due to the potential risks
- C. Do not prescribe stimulants until the patient reports clearer symptoms of attention-deficit hyperactivity disorder
- D. Prescribe a limited course of stimulants to enhance the therapeutic alliance and retain the patient in treatment
- E. Respect patient autonomy and prescribe stimulants as requested

Submit

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- A. Do not prescribe stimulants as the patient is only being influenced by popular literature and pharmaceutical advertisements (5%)
- ✓ B. Do not prescribe stimulants due to the potential risks (78%)
- C. Do not prescribe stimulants until the patient reports clearer symptoms of attention-deficit hyperactivity disorder (13%)
- D. Prescribe a limited course of stimulants to enhance the therapeutic alliance and retain the patient in treatment (1%)
- E. Respect patient autonomy and prescribe stimulants as requested (0%)

Omitted
Correct answer
B

78%
Answered correctly

05 secs
Time Spent

01/27/2020
Last Updated

Explanation

Nonmaleficence, or the injunction "primum non nocere" (**first, do no harm**), instructs physicians to avoid procedures or treatments that cause harm unless the benefits of treatment outweigh the potential harm. In this case, the physician does not believe that the patient has a disorder that

Explanation

Nonmaleficence, or the injunction "primum non nocere" (**first, do no harm**), instructs physicians to avoid procedures or treatments that cause harm unless the benefits of treatment outweigh the potential harm. In this case, the physician does not believe that the patient has a disorder that would benefit from stimulant treatment. In addition, the patient has multiple reasons to be at risk of harm from the requested treatment (eg, adverse cardiac events, addiction). The **risks of harm** in this case **outweigh benefits and patient preference**.

(Choice A) The influence of popular literature and/or pharmaceutical advertisements is not a proper reason per se to refuse to provide a certain therapy. It is acceptable to prescribe an advertised drug in response to a patient request if it is an appropriate choice.

(Choice C) Although exhibiting clearer attention-deficit hyperactivity disorder (ADHD) symptoms may increase the possibility of benefit from stimulants, the risks of harm continue to outweigh the benefits in this case. Nonstimulant ADHD medications could be considered if they carry fewer risks.

(Choice D) A therapeutic alliance is based on trust and the provision of appropriate treatment. Retaining a patient in harmful treatment provides no benefit to the patient.

(Choice E) Patient autonomy allows patients to make their own health care decisions regarding accepting or refusing treatment. This concept does not allow patients to demand an inappropriate and risky treatment. The role of the physician is to educate the patient about the risks and benefits of appropriate treatment options and respect the patient's autonomy in deciding to accept or refuse recommended treatment.

Educational objective:
Patients have the right to make decisions about their health care. However, based on the principle of nonmaleficence, the prescription of medications likely to do more harm than good should be avoided, even if requested by patients.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Nonmaleficence
Subject	System	Topic

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A 22-year-old woman is hospitalized due to suicidal ideation. The patient describes feelings of intense sadness, emptiness, and despair for the past week following the breakup of her month-long romantic relationship. For the past week, she has had difficulty falling and staying asleep but has had no change in appetite, energy level, or concentration. She feels betrayed by her boyfriend and is furious at her parents for turning against her. Since the breakup, the patient has been going to bars, engaging in unsafe sex, and drinking excessively. She describes having intense mood swings since adolescence and has a history of 2 suicide attempts involving an overdose of sleeping pills. Which of the following is the most likely diagnosis?

- A. Bipolar II disorder
- B. Borderline personality disorder
- C. Dependent personality disorder
- D. Histrionic personality disorder
- E. Major depressive disorder
- F. Paranoid personality disorder
- G. Substance-induced mood disorder

Submit

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- A. Bipolar II disorder (18%)
- ✓ B. Borderline personality disorder (63%)
- C. Dependent personality disorder (4%)
- D. Histrionic personality disorder (7%)
- E. Major depressive disorder (4%)
- F. Paranoid personality disorder (0%)
- G. Substance-induced mood disorder (1%)

Omitted
Correct answer
B

63%
Answered correctly

02 secs
Time Spent

06/06/2020
Last Updated

Explanation

Borderline personality disorder

Borderline personality disorder	
Clinical features	• Pervasive pattern of behavior beginning at early adulthood; ≥5 of the following: ◦ Unstable self-image ◦ Feelings of emptiness ◦ Unstable relationships ◦ Abandonment fears ◦ Mood instability (intense reactivity lasting hours to days) ◦ Inappropriate anger ◦ Transient paranoia or dissociation ◦ Impulsivity (eg, substance abuse, binge eating) ◦ Recurrent suicidality, self-injury (eg, cutting)
Differential diagnosis	• Bipolar II disorder (distinct hypomanic & major depressive episodes) • Dependent personality disorder (submissive in response to interpersonal stress) • Histrionic personality disorder (no self-destructive behavior or intense anger)

This patient's depression, suicidal ideation, and impulsivity in the setting of feeling rejected are characteristic of **borderline personality disorder** (BPD). Individuals with this disorder exhibit a persistent pattern of **unstable** and **intense relationships** beginning in adolescence or early adulthood. They experience marked **mood reactivity** to interpersonal stresses and frequently alternate between extremes of idealizing and devaluing others (defense mechanism of splitting). Difficulty controlling anger, **impulsivity** (eg, substance use, unsafe sex), recurrent suicidality, and self-mutilating behavior (eg, cutting, burning) are common. Individuals with BPD frequently seek clinical attention due to suicidal behavior or threats during an interpersonal crisis and comprise approximately 20% of psychiatric inpatients.

(Choice A) Although bipolar II disorder and BPD can have similar clinical features, this patient has insufficient symptom quantity and duration to diagnose discrete episodes of hypomania and major depression required for the diagnosis of bipolar II disorder. BPD is characterized by transient mood shifts and impulsive behaviors that occur in response to environmental triggers (eg, relationship breakup).

(Choice C) Individuals with dependent personality disorder fear abandonment but respond to relationship strain by trying to appease others,

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(Choice C) Individuals with dependent personality disorder fear abandonment but respond to relationship strain by trying to appease others, versus being impulsive and having uncontrolled anger as seen in BPD.

(Choice D) Both borderline and histrionic personality disorders are characterized by attention-seeking behavior, but this patient's excessive anger and self-destructive behavior are more characteristic of BPD.

(Choice E) This patient has insufficient symptom quantity and duration for a diagnosis of major depressive disorder (MDD). In MDD, ≥5 of the following symptoms are present for ≥2 weeks: depressed mood, sleep disturbances, anhedonia, guilt, decreased energy, concentration difficulty, appetite changes, psychomotor retardation or agitation, and suicidality.

(Choice F) Patients with BPD may experience transient, stress-related paranoid ideation but do not exhibit the pervasive pattern of distrust and suspiciousness characteristic of paranoid personality disorder.

(Choice G) This patient's alcohol misuse is a consequence, not the cause, of her behavioral disturbance.

Educational objective:
Borderline personality disorder is characterized by a persistent pattern of unstable relationships, mood lability, and impulsivity. Individuals with this disorder may exhibit suicidal ideation or behavior in the context of an interpersonal crisis in which they feel rejected or abandoned.

References

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References

- Borderline personality disorder and bipolar disorder: what is the difference and why does it matter?
- Borderline personality disorder in the primary care setting.
- Using negative emotions to trace the experience of borderline personality pathology: interconnected relationships revealed in an experience sampling study.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Personality disorders
Subject	System	Topic

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A 72-year-old retired man with end-stage renal disease becomes agitated during dialysis and attempts to abruptly leave in the middle of the procedure. The patient accuses the staff of violating his rights and stealing his belongings but then appears to fall asleep. Fifteen minutes later, he becomes violent and requires restraints. Medical history is significant for hypertension, type 2 diabetes mellitus, hyperlipidemia, and peripheral vascular disease. The patient has a history of major depression that has been in remission for 15 years. His wife says that he has experienced mild memory and word-finding difficulties over the last year and that he often needs to make lists to remind himself of errands; however, she has never witnessed this type of agitated behavior. Temperature is 38.3 C (100.9 F), blood pressure is 112/63 mm Hg, pulse is 93/min, and respirations are 18/min. The patient has a left carotid bruit, and a dialysis catheter is present in the right internal jugular vein. Bronchial breath sounds are heard at the right lung base. During neurologic evaluation, he is confused but cooperative with no focal findings. Which of the following is the most likely explanation for this patient's current behavior?

- A. Alzheimer disease
- B. Brief psychotic disorder
- C. Delirium
- D. Depression with psychotic features
- E. Frontotemporal dementia
- F. Vascular dementia

Submit

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- A. Alzheimer disease (5%)
- B. Brief psychotic disorder (4%)
- ✓ C. Delirium (64%)
- D. Depression with psychotic features (2%)
- E. Frontotemporal dementia (10%)
- F. Vascular dementia (12%)

Omitted
Correct answer
C

64%
Answered correctly

02 secs
Time Spent

01/21/2020
Last Updated

Explanation

Explanation

Clinical features of delirium, dementia & depression in the elderly			
	Delirium	**Dementia**	**Depression**
Onset	Acute	Gradual (months to years)	Gradual (months)
Consciousness	Impaired	Intact	Intact
Course	Fluctuating	Progressive	Episodic
Prognosis	Reversible	Irreversible	Reversible
Memory impairment	Global impairment	Remote memory spared	Moderately impaired focus/concentration

This acute onset of mental status change is most suggestive of **delirium**. Delirium is a **reversible, acute confusional** state involving a reduced or **fluctuating level of consciousness** (eg, somnolent to combative within a short time); there are difficulties sustaining attention and significantly impaired memory and executive function. It is most commonly seen in elderly patients with medical illness and is often associated with anxiety, agitation, delusions, and/or hallucinations. Patients of advanced age and with neurologic conditions such as Parkinson disease, dementia, and prior stroke are more likely to develop delirium due to reduced cognitive reserve.

The presence of delirium in this patient indicates an unstable underlying medical condition that must be identified and treated. The patient's elevated temperature and bronchial breath sounds are likely due to an underlying pulmonary infection. Once the underlying medical condition is effectively treated, the delirium should resolve.

(Choices A, E, and F) In contrast to delirium, the dementia in Alzheimer disease, frontotemporal dementia, and vascular dementia is gradual in onset and progressive without much fluctuation. In Alzheimer disease, attention and remote memory are spared initially, and there is no impairment of consciousness until late in the disease. Frontotemporal dementia presents with early behavior change (eg, disinhibition, apathy), followed later by memory impairments. Vascular dementia involves a stepwise decline typically associated with focal neurologic signs and does not impair consciousness in the early stages. Although this patient's mild cognitive impairments over the past year may gradually progress to dementia, they would not explain his acute confusional state, which is a rapid change from his baseline.

Explanation

C	
Conso	
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Memory	

This acute onset of menta ... ed
or **fluctuating level of co** ... ntly
impaired memory and exe ...
agitation, delusions, and/c ... d
prior stroke are more likel

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(Choices A, E, and F) In ... in
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Exhibit Display

Causes of delirium	
Predisposing risk factors	• Dementia • Parkinson disease • Prior stroke • Advanced age • Sensory impairment
Precipitating factors	• **Drugs** (eg, narcotics, sedatives, antihistamines, muscle relaxers, polypharmacy) • **Infections** (eg, pneumonia, urinary tract infection, meningitis) • **Electrolyte disturbances** (eg, hyponatremia, hypercalcemia) • **Metabolic derangements** (eg, volume depletion, vitamin B_{12} deficiency, hyperglycemia) • **Systemic illnesses** (eg, congestive heart failure, hepatic failure, malignancy) • **Central nervous system conditions** (eg, seizure, stroke, head injury, subdural hematoma)

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(Choice B) Brief psychotic disorder is characterized by the sudden onset of psychotic symptoms lasting ≥1 day but <1 month that is not better explained by another medical condition. In contrast to patients with delirium, those with psychotic disorders are typically alert and oriented.

(Choice D) Major depression can sometimes be accompanied by delusions or hallucinations (eg, voices telling patients they are worthless). The absence of current depressive symptoms, acute onset, and fluctuating level of consciousness make this diagnosis unlikely.

Educational objective:
Delirium is a reversible, acute-onset confusional state characterized by a fluctuating level of consciousness with deficits in attention, memory, and executive function. In contrast, dementia has a gradual onset, is irreversible, and does not involve fluctuations in consciousness.

References

- Geriatric psychiatry review: differential diagnosis and treatment of the 3 D's - delirium, dementia, and depression.
- Delirium in older persons: advances in diagnosis and treatment.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Delirium
Subject	System	Topic

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A 19-year-old man comes to the office for evaluation of a hand injury. He says, "I was just minding my own business at work when this dog bit me." The patient recently started operating a dog-fighting club and adds that his "entrepreneurial skills" have made him "richer than a doctor." He has been fired from multiple jobs, most recently while working as a car salesman, due to getting into arguments with coworkers and being repeatedly late to shifts. The patient says, "I was only late a few times. Haven't you ever been late before, doc?" During middle school, he was recurrently truant and spent time at a juvenile detention center for tampering with his teacher's car brakes after failing a class. Which of the following is the most likely diagnosis?

- A. Antisocial personality disorder
- B. Borderline personality disorder
- C. Conduct disorder
- D. Disruptive mood dysregulation disorder
- E. Intermittent explosive disorder
- F. Narcissistic personality disorder
- G. Oppositional defiant disorder

Submit

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- ✓ A. Antisocial personality disorder (66%)
- B. Borderline personality disorder (3%)
- C. Conduct disorder (12%)
- D. Disruptive mood dysregulation disorder (1%)
- E. Intermittent explosive disorder (0%)
- F. Narcissistic personality disorder (7%)
- G. Oppositional defiant disorder (7%)

Omitted
Correct answer
A

66%
Answered correctly

02 secs
Time Spent

06/10/2020
Last Updated

Explanation

Antisocial personality disorder

Antisocial personality disorder	
Clinical features	• Violates rights of others, social norms, laws • Impulsive, irritable, aggressive (fights, assaults) • Consistently irresponsible, lies, is deceitful • Lack of remorse • Age ≥18 • Evidence of conduct disorder before age 15
Differential diagnosis	• Borderline personality disorder (exploitative behaviors related to abandonment fears) • Conduct disorder (pattern of violating societal norms & rights of others; age <18) • Narcissistic personality disorder (no pattern of violence or criminal activity)

This patient's operation of an illegal dog-fighting ring, unstable employment history, irritability with coworkers, and repeated tardiness to work are most consistent with a diagnosis of **antisocial personality disorder** (ASPD). This disorder is characterized by a pattern of disregard for and **violation** of the **rights of others**, beginning by early adolescence and persisting into adulthood (**age ≥18** required for diagnosis). An essential feature for diagnosis of ASPD is evidence of **conduct disorder prior to age 15** (eg, this patient's history of truancy and vindictive behavior toward his teacher).

Individuals with ASPD display consistent **irresponsibility** along with **impulsivity** and irritability, which may result in **physical aggression**. Engagement in criminal activities (eg, theft, illegal occupations) and **lack of remorse** for transgressions are typical in this disorder.

(Choice B) Borderline personality disorder also consists of a pattern of impulsivity and manipulation. These individuals have marked emotional lability, tend to be less physically aggressive, and display exploitative behaviors that are often driven by abandonment fears as opposed to personal gain and/or profit.

(Choice C) When individuals with conduct disorder continue to display a pattern of violating the rights of others into adulthood (age ≥18), they are diagnosed with ASPD.

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(Choice C) When individuals with conduct disorder continue to display a pattern of violating the rights of others into adulthood (age ≥18), they are diagnosed with ASPD.

(Choice D) Disruptive mood dysregulation disorder is characterized by severe, persistent irritability in childhood, accompanied by frequent verbal and/or aggressive outbursts. This diagnosis is usually restricted to individuals age <18.

(Choice E) Intermittent explosive disorder also consists of recurrent impulsive and destructive outbursts, but they are neither premeditated nor related to achieving secondary gain (eg, profit, intimidation).

(Choice F) Although this patient exhibits some grandiosity, lack of empathy, and exploitative behaviors that are also characteristic of narcissistic personality disorder, these would not explain his lifelong pattern of involvement in violent and/or criminal activities.

(Choice G) Oppositional defiant disorder similarly consists of irritability and vindictiveness as well as a lack of personal accountability for behaviors. However, individuals with this disorder do not have a pattern of engaging in criminal activities.

Educational objective:
Antisocial personality disorder involves a pattern of violating the rights of others, engaging in unlawful behaviors (eg, physical aggression, illegal occupations), and lacking remorse for transgressions. Individuals must be age ≥18 for diagnosis and have a history of conduct disorder prior to age 15.

References

- Antisocial personality disorder: a current review.

A 63-year-old woman with a history of metastatic breast cancer comes to the office due to depressed mood. Over the past month, the patient has become increasingly sad and frequently cries when thinking about her poor prognosis and dying. She has lost 4.5 kg (10 lb) over the past month. Her energy level is low, and she has difficulty falling asleep and frequent nighttime awakenings. The patient has become very withdrawn, doesn't answer the phone, and no longer looks forward to family visits. She feels bad about not wanting to be around her grandchildren. On mental status examination, the patient is alert and oriented with depressed mood and affect. She has no suicidal ideation. Which of the following symptoms is most indicative of major depressive disorder in this patient?

- A. Loss of interest in family
- B. Low energy
- C. Sleep disturbance
- D. Thoughts of dying
- E. Weight loss

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- ✓ A. Loss of interest in family (71%)
- B. Low energy (4%)
- C. Sleep disturbance (8%)
- D. Thoughts of dying (12%)
- E. Weight loss (2%)

Omitted
Correct answer
A

71%
Answered correctly

01 sec
Time Spent

01/15/2020
Last Updated

Explanation

Major depressive disorder	
	• ≥5 of the following symptoms lasting ≥2 weeks (at least 1 symptom must be either depressed mood or loss of interest/pleasure):

Major depressive disorder	
Diagnosis	• ≥5 of the following symptoms lasting ≥2 weeks (at least 1 symptom must be either depressed mood or loss of interest/pleasure): ◦ Depressed mood ◦ Loss of interest or pleasure ◦ Change in appetite or weight ◦ Insomnia or hypersomnia ◦ Psychomotor retardation or agitation ◦ Low energy ◦ Poor concentration or indecisiveness ◦ Thoughts of worthlessness or inappropriate guilt ◦ Recurrent thoughts of death or suicide • No history of mania or hypomania • Not due to substances or another medical condition
Treatment	• Psychotherapy • Antidepressant medication

Diagnosis of major depressive disorder in **patients with cancer** is challenging as **somatic symptoms of depression overlap** with those of cancer and/or the adverse effects of cancer treatments. This patient's weight loss, low energy, and sleep disturbance may also be due to metastatic cancer and/or chemotherapy. Therefore, these somatic symptoms are less reliable indicators of major depression **(Choices B, C, and E)**.

Nonsomatic depressive symptoms (eg, feelings of worthlessness, excessive guilt, and suicidal ideation) are more reliable for diagnosing depression in patients with advanced medical illness. This patient's withdrawal and inability to enjoy family visits (ie, **loss of interest and anhedonia**) are therefore the most concerning symptoms for major depression.

(Choice D) Thinking about death and dying is normal in patients with advanced cancer and a poor prognosis. If the patient's thoughts of death

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(Choice D) Thinking about death and dying is normal in patients with advanced cancer and a poor prognosis. If the patient's thoughts of death included suicidal ideation, intent, or plan, this would be indicative of major depression.

Educational objective:
Somatic symptoms of depression (weight loss, low energy, sleep disturbance) are less reliable indicators of major depressive disorder in patients with advanced medical illness. Focusing on nonsomatic symptoms, such as loss of interest, anhedonia, worthlessness, excessive guilt, and suicidality, can assist in diagnosing comorbid depression in these patients.

References

- Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation.
- Distinguishing depressive symptoms from similar cancer-related somatic symptoms: implications for assessment and management of major depression after breast cancer.

Behavioral science	Psychiatric/Behavioral & Substance Abuse	Depression
Subject	System	Topic

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